Sleeping with ROCD

Power for the Co-Sufferer of Relationship OCD

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Introduction

Relationship Obsessive-Compulsive Disorder is widely unrecognized as a special form of Obsessive-Compulsive Disorder. Internet searches typically provide little results for those looking for information about the issue. Therapists and other professionals often are not aware of the problem, and don't really know how to treat it properly.

Many relationships are affected by ROCD, yet most don't realize it. These are often classified as unfortunate normal occurrences due to incompatibility. If ROCD received more attention, it is possible that many relationships may have been saved, and fewer hearts broken. Such is the tragedy of an unrecognized mental disorder.

The purpose of this book is to provide much needed insights and information to those desperate to understand Relationship Obsessive-Compulsive Disorder. Additionally, perhaps if a book is written about it, it may draw more attention from professionals. In which case more understanding and better treatments may follow.

As of now, ROCD would be treated as do other OCD cases. The problem is that ROCD manifests differently than do most traits of OCD. For example, responses to anxiety are not typically portrayed as an observable behavior. The obsessional behavior of ROCD takes place in the privacy of the sufferer's mind, making it easier to hide, and harder to detect.

This presents difficulties for normal OCD treatments to be effective, as many, including CBT, focus primarily on what can be observed. ERP (Exposure and Response Prevention) focuses on resisting responses (behaviors) that result from anxiety.

Since the responses take place in the mind, rather than observable behaviors, ERP will probably take longer, and would be less effective than in other cases of OCD.

For these reasons, it seems imperative that someone speaks up about ROCD, and lays the initial groundwork for further investigation. Without this, ROCD may continue to go on undetected, untreated, and uncontrolled. This result would be tragic to both sufferers and their partners.

This book was written for the partners in these relationships, to help identify ROCD, understand it, and protect themselves from the damages often incurred from these relationships. Many partners don't know what to do, and suffer significant sadness due to ROCD. This book is intended to bring some relief to these partners, and give them power to address ROCD, and protect their relationships from disaster.

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Power for the Co-Suffer of Relationship OCD

By D. M. Kay

For Marty-
May you find your freedom,
both within and without.
All my love.

“Love is a journey,not a destination.”
~Unknown

“Rome wasn’t built in a day.”
~John Heywood

Chapter One:

What is Relationship Obsessive-Compulsive Disorder?

This chapter refers to common features of Relationship Obsessive-Compulsive Disorder (ROCD), and descriptions based on reports of experiences provided by sufferers, partners of sufferers, and professionals with knowledge of ROCD or its characteristics. This chapter is for informational purposes, and identifying the ***potential*** for ROCD. It is not for diagnosing yourself or your partner. Please consult a qualified professional for diagnosis and treatment.

The circumstances or events described in this chapter have occurred in some cases, but have not occurred in all ROCD relationships. Additionally, not all events or circumstances that have occurred in ROCD relationships are described here.

ROCD is an acronym for Relationship Obsessive-Compulsive Disorder. It is a term that was adopted, mostly by sufferers, for lack of an official name. This refers to a form of OCD that appears in the close or intimate relations of the sufferer. This often accompanies other traits of OCD, whether currently or previously active.

There is a noticeable lack of information available to help both sufferers and loved ones understand this disorder. Additionally, many mental health professionals familiar with OCD are unfamiliar with the details of ROCD. It appears that there is not enough information or attention to this form of OCD in the medical community.

Some Relationship Obsessive-Compulsive Disorder cases may not include other severe OCD traits. There have been some reports among sufferers that professionals specializing in Obsessive-Compulsive Disorder lack understanding of ROCD, and its features. It is common for psychiatrists and psychologists to deny the existence of ROCD, because it is not an official term.

Though sufferers and some experienced OCD specialists strongly object, the problem is treated like it doesn't exist individually. This can lead to misdiagnosis and improper treatment, a failure of the mental health profession concentrated on compulsive and obsessional behavior.

Specifically...

Relationship Obsessive-Compulsive Disorder a the term commonly used to describe an Obsessive-Compulsive Disorder condition in which the sufferer obsesses over justifying remaining in an intimate relationship. This disorder is a

form of Obsessive-Compulsive Disorder, and involves paranoia and unrealistic reasoning. It is cyclic, excessive, obsessive, and uncontrollable without help. It is known to cause the sufferer extreme difficulties in intimate relationships, and affects partners involved. It is treated using the same methods as those of OCD treatment, with some differences. There are other behaviors or obsessions mistakenly confused with ROCD, such as fear of cheating, which exclusively classifies as "intrusive thoughts". As with other OCD-classified disorders, such as Body Dysmorphic Disorder, Relationship Obsessive-Compulsive Disorder is specific to certain subjects. "Doubting" and "checking", common symptoms of OCD, is present in cases of ROCD.

Are you the One?

A person with ROCD experiences ruminations on a wide variety of issues, including sexual orientation, stereotyping, compatibility, defects, and fears of lovelessness. The root of this is a need to be sure that he or she is making the correct decision about remaining in a partnership. There is an abnormal fear of making a mistake in the choice of a partner.

In justifying the relationship, the ROCD sufferer directs his or her attention to flaws. These include minor personality differences, perceived public or social disapproval, and other possible negatives. Minor issues, normally viewed as insignificant, are given excessive weight in deciding the quality of his or her relationship.

The details involved in deciding the quality of the partner ranges widely, but are commonly ones easily ignored in normal healthy relationships. Some examples of these justifications are as follows:

"I would be happier if I were with someone like her, but who is a brunette."
"I would be happier if I were with a man who didn't have bad breath."
"Since she and I have a different sense of humor, she can't be the one for me."
"I can't be with someone who has a weird laugh."
"I am attracted to other women, which means I must not love my partner enough."
"He doesn't fit in with my friends. He must not be right for me."
"I don't long for her when she is gone. I must not be in love."

"Be like Mike"

In ROCD, the idea of a good, healthy partnership does not come from a practical basis, but rather unrealistic notions of perfection. The sufferer often compares the relationship to those portrayed in movies, or other media, and to their unfounded opinions of others' relationships. For example, a movie portrays a scenario where a man has given up on love after a string of unsuccessful relationships. He meets woman, and, over time, learns that she has everything in common with him. They end up together, followed by the "happily ever after" suggestion.

That one can find a perfect person whose personality meshes in every way is impossible. However, this is the goal, which leads to repeated failed relationships, or repeated breakups in a single partnership. Healthy relationships involve the *choice* to commit, cooperation, work, and are never perfect. This fact escapes the logic of the ROCD suf-

ferer. This person is basing his or her commitment level in the relationship on emotional response rather than by choice. ROCD enforces the need for correctness, thus the ever-present indecision, confusion, and obsession.

The 'greener grass' expression strongly applies to ROCD. The person tests the relationship by comparing it to those of others. For example, a man with ROCD sees a couple walking down the street, whose relationship appears healthy and happy. He sees them smile at each other, holding hands, seemingly perfect together. Under the scrutiny of ROCD, he decides that his partnership is not like theirs, thus must not be the right one for him. “Their relationship is perfect, and mine is not. Therefore, I must be with the wrong person.” Unfortunately, ROCD causes him to forget that he, too, has moments like that with his partner. He rationalizes that since he doesn't long for her all the time, and doesn't always feel 'in love', he must not love her.

A person with ROCD is constantly questioning what would make him or her happy and who would be “the one” for him or her. They compare this 'perfect' picture to the *imperfect* person they are with. This can only lead to one conclusion, which is the partner is not the one for them.

Blast from the Past

A trait often seen in ROCD is an abnormal retention to past relationships. The sufferer wonders if he or she made the right choice in ending it. The root of this is often the fear that he or she already passed up “the one”. With ROCD, this goes on well past what is considered normal, causing the sufferer confusion for up to several years after the relationship ended.

ROCD sufferers may compare the current partner with past partners, which results in one of two possible outcomes. Either the partner doesn't sufficiently resemble the ex-lover, or they are too similar. This can amount to relationship disqualification. Obsessions can develop where the sufferer wants a partner who looks like past loves, including likenesses such as height, weight, nationality, age, or occupation. The sufferer uses this 'typing' as important grounds to stay in or leave the relationship. Partners who do not fit the profile are rejected regardless of how otherwise healthy the relationship is.

For example, an ROCD sufferer, after spending years in his relationship, justified ending it because of his partner's appearance. She was a tall, thin, blond Caucasian. This did not fit his "type", which was a short, curvy, brunette of Latin nationality. It was discovered that he had two past relationships that ended not by his choice. The common feature of these relationships was the two women sharing that "type". The ROCD sufferer resolved that since his current partner did not have these traits, she could not be right for him, despite the presence of significant features of a good relationship.

Is it Mr. Or Ms. Right?

ROCD sufferers can experience obsessions over sexual orientation. This is a feature not exclusive to ROCD, and is a common trait of OCD. With ROCD, this occurs following a series of unsuccessful relationships with partners of the opposite sex. The sufferer may think, "Since I haven't been able to feel love for the women in my life, perhaps I am gay." They may test themselves for clues of homosexuality.

The person may imagine circumstances where homosexual acts take place, to test emotional response. In some cases, the person will actually engage in this activity in effort to confirm or disqualify the idea.

Is this Love?

ROCD can hinder a person's ability to enjoy moments of intimacy, or what would normally be an enjoyable experience between partners. Instead, he or she analyzing his or her emotional response. Unable to relax and enjoy a good time, the person is asking themselves if the emotional connection they feel is substantial enough to justify remaining in the relationship. The question is,"Do I feel love right now?" This is counterproductive as it starts the obsessing, resulting in emotional void. The person expects to always feel "in love" when with the right partner. Lack of this emotional intensity is viewed as a signal of a bad partnership.

Now you see it. Now you don't.

For the partner, this is equally, if not more confusing. The sufferer usually confesses their feelings of doubt, and will reveal the reasons to the partner. The partner will often hear statements like "I care about you, but I don't think I love you.", "I can't get over (minor flaw), so I can't be with you."or "I want to be with someone who thinks like me." This subjects the partner to repeated criticism, hurt feelings, and confusion.

ROCD appears intermittently, therefore the partner experiences moments of feeling like everything is going well, followed by drastic reversal. ROCD is often described as manic-depressive in nature. Spikes often occur soon after a

time of significant happiness with the partner. Partners describe this relationship as an emotional roller coaster ride, where the emotional energy is either "way up", or "way down".

ROCD allows no distinction or recognition of the differences between feelings prior to the spike and those during a spike. Because the sufferer feels no love now, it must mean they never did, thus the common complaint by partners that the sufferer forgets previous feelings of love and enjoyment. This often leads to a confrontation where the partner asks the ROCD sufferer to explain various contradictions to their confessions. These questions or statements are or are similar to the following:

"But just last week you said you were happy with me. What happened?"

"You tell me all the time that you love me. Were you lying?"

"This isn't right. Is this a joke?"

"We were just talking about (*moving in together, getting married; having children...*). Why the sudden change?"

"Everything seemed fine. What did I do wrong?"

"You were certainly attracted to me the other night."

In Denial

This also confuses the sufferer, but because of the spike, he or she will work to provide explanations that result in confirming or supporting feelings *now*. The sufferer may even acknowledge the inconsistency or contradictions. The explanations rarely make sense, further confusing the partner. Explanations are often or similar to "I was only trying to make you happy", "It seemed like the right thing to say",

“That's not what I meant”, “That's not what I said”, or “I don't know why I said that”.

In his or her mind, the contradictions cannot be valid because they are not true *now*. As a result, the partner begins to wonder what is real, and what isn't. The truth is that it is all real. The sufferer is unable to recognize that it is OCD that is causing a defect in his or her perception. He or she can only deny that his or her feelings were ever any different from what they are now, because that is what *appears* to be true.

Zipped Lip

Sometimes, although the sufferer may recognize the pattern, he or she will engage in actions that will spare them future confrontation. The sufferer avoids any more claims or acts of affection, including saying “I love you”, even when those feelings are present. This is because he or she is unsure of *true* feelings due to ROCD and fears these expressions will be used against them later.

Don't tell **me** *how I feel*

Another common response to the confrontation is anger. The sufferer resists attempts to change his or her mind. They refuse to listen to the partner when naturally confronted about the odd nature of the circumstance. The sufferer has gone to great lengths, in his or her mind, to justify the belief that they are with the wrong partner. The partner's challenges produce more confusion. Considering the purpose for the conclusions is to *relieve* confusion, the sufferer is stubborn or combative in response to *added* confusion.

A Bad Rap

A common misinterpretation of a sufferer's behavior is that he or she is a liar, playing head games, immature, or just mean. The truth is that he or she is usually being honest, both in confessions of love, and confessions of the opposite. This is difficult to understand for people who are unfamiliar with ROCD. It isn't that he or she is or was lying to the partner, it is that ROCD is causing sufferer to lie to themselves.

Wolf in Sheep's Clothing

During an onset of ROCD, the sufferer may experience thoughts that he or she is lying to or fooling those close, as a result of the conclusion that he or she does not love the partner. For example, while a couple is at dinner with the partner's parents, the suffer has persistent thoughts about how he or she is lying to everyone, including the parents. Thoughts in this circumstance are or are similar to the following:

"You have no idea that I don't love your daughter."

"I'm lying to all of you, and you don't even know it."

"I am an awful person for stringing these people along like this."

The sufferer can experience feelings of guilt or shame due to the idea that the relationship is a farce, because he or she is only pretending to love the partner, and is fooling everyone involved.

This eventually leads to confession and, possibly, a subsequent breakup, as the sufferer cannot handle the guilt involved in staying with someone they don't love. He or she

must end the relationship because staying in it is to continue living a lie.

Big Red Button: Closing the Back Door

Spikes, or the onsets of obsession, have triggers. In ROCD, these mainly have to do with commitment. The idea of getting married is a major spike-inducer, as well as moving in together, or any other joint endeavor that could represent committing to the relationship. To understand the reason for this is to understand ROCD, which is the obsession over the justification for staying in a relationship. To ask for or suggest commitment is like asking a person suffering claustrophobia (fear of small spaces) to climb into a foot locker and close the lid on themselves.

Other Buttons

Other spikes inducers include unfavorable remarks by the sufferer's friends or family about the partner. Disagreements or arguments with the partner, contact with an ex-lover, watching a romantic movie, and many other circumstances can also induce a spike. If the partnership experiences a rough patch, as all will do, it can mean total relationship failure to the ROCD sufferer.

It's all in your head

ROCD is a form of heightened self-absorption. The sufferer's view of what *is* and what *should be* is governed by OCD. Judgments on how others think is a result of the sufferer's theory, which is a compilation of absolutes. In ROCD, deciding the worth of a relationship does not include consideration of the partner's feelings

If there is consideration for the partner's position, it is the sufferer's perception of the partner's thoughts and feelings, often unfounded or irrational. This applies to obsessions about whether the partner loves the sufferer, if the partner will cheat, if the partner is planning to break off the relationship, and other questions stemming from insecurities.

Who are you and what have you done to my baby?

Partners of sufferers of ROCD may notice that, during a spike (or subsequent breakup), the sufferer turns "cold", showing no sympathy, empathy, or guilt. Descriptions of this characteristic are often "Jekyll and Hyde", or "someone else". The sufferer becomes emotionally unresponsive, showing virtually no feelings toward the partner. This can be devastating, as the partner feels not only the rejection, but an absence of any concern that they are being hurt. The sufferer shows no remorse or apparent conception of the pain they are inflicting, appearing quite detached from the matter.

The sufferer is only interested in proving *his* or *her* feelings, and there is rarely room to consider the partner's feelings. Conceiving and empathizing with the pain they are causing is rare. This is because the sufferer has concluded that he or she does not love the partner. Empathy or remorse would indicate feelings, which ROCD has "told" them they don't have. This "cold" nature is in accordance to that affirmation.

Is it me or...

The sufferer may know about his or her ROCD and how it is affecting them. However, during a spike, the sufferer

has no way of knowing the difference between what is real, and what is ROCD, because ROCD has almost total control of the sufferer's logical process. The sufferer can only be open to the *possibility* that it is OCD, however this does not change the effect. A person with ROCD is a victim of his or her own mind.

The Aftermath

When the spike subsides, the sufferer will naturally regret his or her action. The sufferer realizes the mistake, and can experience significant depression due to the harm done to the partner, and, if applicable, the loss of the partner. The timing of the realization varies from days to months, but usually occurs at a point when the sufferer recognizes that he or she *does* love the partner. However, the sufferer may hold onto the doubt until the relationship has ended, and even for a period after that.

The partner, usually deeply hurt, may or may not return to the relationship. Each time this occurs, partners can experience a lessening of trust, patience, and eventually the loss of will to remain in the relationship. If the sufferer fails to recognize or acknowledge ROCD, how it affects the partner, and get help, the partner may experience a significant loss of affection toward the sufferer.

It Never Ends

If the relationship ends, and the sufferer is able to move on to another partner, the cycle eventually begins again. ROCD is inside the sufferer's mind, and is not caused or created by the previous partner. The indecision does not go away with the previous relationship, but eventually rede-

velops in the new relationship. OCD does not go away on its own. Obsessions can, however, change subjects and become temporarily dormant.

Chapter Two:

Signs of Obsessive-Compulsive Disorder

ROCD is often a subsequent feature of Obsessive-Compulsive Disorder, and is rarely a standalone illness. Identifying traits of OCD that are not exclusive to ROCD is helpful in determining the potential for ROCD. If your partner displays OCD traits in other areas of life, he or she is more likely to have ROCD, if ROCD traits are already present in your relationship.

Please consult a mental health professional for diagnosis. The information and experiences described in this chapter are not for the purpose of diagnosis, but are accounts of experiences of others.

OCD tendencies can be present without the presence of ROCD.

Obsessive-Compulsive Disorder affects 2% to 3% of the U.S. population. It is the fourth most common psychiatric illness in the United States, and ranks #10 in the highest causes of disability. Studies show that only a fraction of OCD sufferers get diagnosed and treated. This means many OCD sufferers don't know that they have it, and are not receiving treatment.

As The Fog Lifts...

K. D. writes:

"In the early part of my relationship with my partner I would joke and tease him about being OCD. At the time, I had no idea how true that was.

I remember a disagreement about how to load the dishwasher. He had to have the silverware pointed down, so the handles were up. I disagreed, stating that I wanted to put the part that goes into your mouth up, so the dirt would run down the handle. I didn't press the issue, but I did take note of how he was not open to my suggestion. It had to be his way.

Another memory I have is wondering if he owned a vacuum. I never saw it in his apartment, and I was there enough that one would think I'd have seen the tracks, at least. Never. What I did see was my partner picking up dust and lint with his fingers. One by one, he'd lean over and collect little pieces of litter, and throw them away. I asked him once if he owned a vacuum. He had one, but apparently didn't use it very often.

One of most telling signs of OCD was a time when he confronted me about toilet paper. He called me into the bathroom where I found him holding a roll. He asked me, "On what side is the paper supposed to roll off?". I thought this was odd, but I only responded with, "Well, the top, I think." He confirmed that this was correct, and told me that I had loaded it to roll from the bottom. "My mistake." I replied.

At the time, I viewed these traits as mere personality quirks. I never thought about OCD, other than to joke with him about his "needs" every so often. It was later in the relationship that I realized there may be more to OCD than I previously considered.

It started when he began to get irritated with me for being, well, not perfect. Once past the newness of our relationship, I started having my flaws regularly addressed. Obviously, when you are with someone and you love them, your first thought isn't usually that there's something wrong with your partner. In my case, I took it as something wrong with me.

For example, one evening, outside a pizza shop where we'd just eaten dinner, we were having a discussion. He told me that he did not like the way I dressed. This surprised me, and I asked, "What's wrong with the way I dress?" He replied by listing everything he didn't like about my outfit, from my earrings, to my belt, to my shoes. It hurt to have him criticize me this way.

Another example of this behavior occurred one day when I was in the driveway, washing my car. My partner approached me, and made small talk for a moment or two.

Then he informed me that he didn't want me to do my hair the way I had done it that day. My hair was a bit short, but I put it in two small pigtails at my neck. I liked it. He told me that (at 25) I was too old to have my hair like that. I told him that I liked it, and didn't apologize for it. Although I didn't say anything, it did hurt my feelings.

The first sign that I was dealing with something serious, occurred one evening when there was a strange "vibe" between the two of us. He was distant with me, and I noticed an apparent withdrawal of affection.

After this had continued for most of the evening, I finally asked him what was going on. He was reluctant to tell me anything was wrong, but I pressed the issue, telling him that I have noticed his behavior. I told him that if I had done something wrong, he should tell me. He agreed to talk, but it turned out that I hadn't actually done anything. He confessed that he had been having doubts about his feelings for me lately. My heart sank, but I only asked why. He told me there were things about me that he could not get over, flaws that he couldn't stop thinking about.

The first flaw that he told me was making it hard for him to love me was saliva. Apparently I have a wet mouth, and sometimes when I talk, I get a spit string or two between my upper and lower teeth. There were a couple of other, equally ridiculous issues that he told me about afterward. I became angry, hurt, and bewildered by this. I could not believe that he would make such a big deal over such small details. He insisted that he couldn't be with me, and that we had to break up. We stayed together, however this behavior continued on and off, throughout the term of the relation-

ship. We did eventually break up, but I stayed in contact.

Later, we got back together. It wasn't long before it started again. Although the reasons were different, there were frequent confessions about how he didn't like "this" or "that" and how he wanted to be with someone who had certain other features. These were all either minute or untrue. I had heard claims that I was unattractive, I looked old, I didn't fit in with his friends, and many other stupid and frustrating excuses for why he couldn't love me. One can imagine how this can hurt.

I loved him, so I didn't leave, which I am sure most would have done by then. Instead, I started doing research on this behavior. I now knew that this wasn't normal, and there had to be other people out there that were going through the same trouble. That was how I found out about ROCD.

He not only displayed significant traits of ROCD, he also had other OCD tendencies. Finally, after repeated requests, he agreed to meet with a mental health professional, who told him that he had OCD tendencies. My partner discovered that he also had traits of OCPD (Obsessive-Compulsive Personality Disorder).

My partner had OCD tendencies, though he did not have many of the common OCD traits, such as hoarding, checking, and counting. His OCD was well hidden from those not as close to him."

In the forgoing summarization of her personal experiences, K. D. was specific to *some* circumstances and experi-

ences. The extent of the ROCD and the OCD presence in her relationship, and in her partner's life was larger and in more forms than she disclosed. The point was to show how she identified OCD and ROCD in her relationship.

To understand ROCD, one must have an understanding of OCD.

No Brakes

Some theorize that a sufferer of OCD lacks the ability to put closure on experiences, which explains the abnormal durations of behaviors and obsessions. It appears that there is no recognition of boundaries or limits in the obsessional behaviors. The sufferer is unable to stop the behavior because they have given the subject or issue exaggerated or irrational significance.

In contradiction to this theory, there is also the idea that instead of having the inability to stop, the sufferer has an inability to feel reassured by obvious and compelling information (via the senses or environmental provisions). Without a reason to stop, the sufferer continues the obsession and behavior.

It is believed that OCD sufferer's obsessions represent or are linked to a perceived threat. The fear associated with the threat turns into anxiety. This justifies the behaviors associated with the obsession, as the sufferer is making efforts to prevent something bad from happening, and relieve the fear.

Because the threats are only 'potential', and are not imminent, the behaviors continue practically endlessly, due to an "open-ended" nature of *potential* danger. Logical certainty

that the threat is gone is unable to be attained.

Hide n Seek

Unless you are looking for it, you may not see some mild forms of OCD until they have become a problem. In a world where everyone has their eccentricities, it is easy to pass signs of OCD off as personality 'quirks'.

OCD is not always severe, nor obvious. Signs can be almost undetectable. Some people have one or two forms, while others have several. Some can have obsessions without compulsions. OCD can transform, as well. Therefore, identifying traits of OCD is not a simple task, nor is it always an “open and shut” case.

Many with OCD, including some children, know that their obsessions, compulsions, and rituals are abnormal and will attempt to hide them. This makes it more difficult for others to identify traits of the disorder.

Obsessions

Obsessions are recurring thoughts, images, and impulses that are often troubling. Though they may start out small or benign, they eventually grow and are associated with fear, leading to anxiety.

Some sufferers realize that they create their obsessions, and that they may be odd. This is an additional source of anxiety, as the sufferer would not choose to or naturally behave this way, and is troubled by the inability to control obsessions.

Compulsions

Compulsions are repetitive and sometimes ritualized behaviors carried out for the purpose of relieving anxieties caused by obsessions.

The following is a list of compulsions that are common in OCD:

Asking for assurances
Arranging or ordering objects
Avoiding situations or places
Cleaning
Counting
Doing certain tasks slowly and deliberately
Doubting and checking
Hoarding possessions and money
Repeating, including speech and action
Washing (e.g., hands, body, teeth)

The following is a list of *some* disorders or behaviors that fall within the spectrum of OCD:

Skin picking (also known as *Dermatillomania*, Compulsive Skin Picking, or CSP): Skin, scab, callous, or pimple picking until the area bleeds or becomes raw.

One example is a case of a man who regularly picked at an area on his lip, creating significant scarring.

Another example is a case where a woman would pick at pimples on her face, turning them into scabs, and would continue to pick at them regularly.

For both, this caused insecurities and embarrassment. Regardless of these feelings, the impulses con-

tinued. Other common areas are the hands, back, stomach, chest, arms, and feet.

Hair pulling (also known as *Trichotillomania*, TTM, or trich): The sufferer will pull hairs from the head, face or body. This commonly results in bald spots.

Nail Biting (also known as Onychophagia)

Nose Picking

Self-inflicted injury

Body Dysmorphia (also known as Body Dysmorphic Disorder or BDD): The person obsesses over imagined or minor defects of his or her body, believing that the appearance of the defect is overly obvious and unnatural. This includes physical shape (too skinny, too fat, etc.), and can be focused on one area or part of the body.

This person is seen either looking in the mirror often, or avoiding it. Some signs of BDD are excessive grooming, concealing (e.g., excessive makeup or baggy clothes), obsession with cosmetic surgeries, excessive exercise or diet, and frequent comparing of his or her body to those of others. This person will often seek reassurances, by routinely seeking compliments, or asking if their appearance is acceptable.

Depersonalization: Believing that physical reality only exists in the mind of the sufferer, and is not real. Self, other people, places, experiences, and other parts of the environment are not real.

Hypochondria (also known as hypochondriasis, or health phobia): Excessive preoccupation or worry over

having a serious illness.

Eating disorders (Bulimia, Anorexia, Compulsive Overeating)

Pathological Gambling: The compulsion to gamble, despite clear indication that gambling would have detrimental results.

Compulsive Shopping

Pyromania Compulsion to set things on fire.

Intermittent Explosive Disorder (IEB): Fits of anger or rage that are disproportionate to the cause.

Intrusive thoughts: Unwanted thoughts occurring such as mishaps, crimes, death or other "bad" events. While it is common for people to be conscientious of safety, the sufferers are overwhelmed by these thoughts.

This is different from violent thoughts, as these are not thoughts of the sufferer deliberately committing these acts, but of the events just "happening".

Excessive occupation with routine: Chores and other activities have to be done in at a specific time, on a specific day, in a specific order or way. This applies to bathing, cleaning, and other tasks.

Magical thinking: Believing certain objects or activities to have "magical" powers, and unusual occupation with superstitions.

One example is a case of a woman who had to "knock" whenever she had a bad thought, such as her home catching fire, or someone getting harmed. While the term "knock on wood" is common in society, she

experienced the need to knock to ensure that these events did not occur. In her experience, the intruding thoughts would sometimes persist, resulting in anxiety, thus repeated knocking.

Another example is a woman who would see a particular make of a vehicle, and believe that it symbolized a coming event. The number of times she saw a vehicle represented the intensity or the timing of the event. This is the act of taking coincidences and giving them magical meanings.

Contamination (also known as Mysophobia or Germaphobia): The fear of contamination and germs through human secretions such as spit, sweat, and urine. This person may avoid using public restrooms, or going to public places. Often seen with this behavior is excessive washing of hands. The sufferer may use tissues to open doors or refuse to touch staircase banisters.

Violent or aggressive thoughts: Thoughts of harming another person or one's self. This person usually doesn't act on these, but encounters regular thoughts of doing harm, such as pushing someone in front of a moving car or hitting someone. These thoughts usually have no reasoning or cause behind them, such as anger toward the person involved.

Substance abuse: Drugs or alcohol used to reduce anxiety, or to lower inhibitions in effort to operate normally in private or social settings. This often leads to addiction, due to repetitive use linked to the idea that one cannot operate properly without the aid of substances.

Substance Addiction

Sexual Compulsion or addiction: Includes excessive masturbation, abnormal interest in porn, frequent encounters with prostitutes, voyeurism, and other unusual behaviors relative to heightened sexual preoccupation. This person may avoid real relationships, replacing these with impersonal physical relationships.

God Complex: The individual believes he or she has supernatural powers, rights, and spiritual placement superior to others.

Divine Purpose: Believing that on exists for a purpose. The purpose is illogical and there is an obsession with fulfilling it.

Possessed: Believing one is possessed or controlled by a separate entity.

Olfactory Reference Syndrome: Excessive preoccupation with one's body odor, resulting in shame and embarrassment.

Tourette's Syndrome

Sydenham's Chorea

Autism

Pica

Generally, the majority of disorders that fall under the following three categories are of, related to, or often accompany OCD:

Anxiety disorders

Impulse Control Disorders

Habit Control Disorders

ADHD (Attention Deficit Hyperactivity Disorder)

ADHD is believed to share a genetic component with OCD, and shares some of its characteristics. Persons with ADHD may also fixate.

Other ADHD tendencies include, but are not limited to fidgeting, excessive movement or bodily adjustment, inability to concentrate, are easily distracted, and an inability to maintain the natural flow of a conversation.

Not Alone

OCD often accompanies other disorders. Reports show that three quarters of children and adults with OCD have other psychiatric illnesses. Other disorders commonly found in association with OCD are **phobias**, **depression**, **post-traumatic stress disorder** (PSTD), **paranoid disorders**, **ADHD**, **Panic Disorder**, and others.

Panic Disorder

It is argued that panic disorders do not fall under the scope of OCD, however both are categorized as anxiety disorders. The following are symptoms of a panic attack:

Sweating

Trembling or Shaking

Shortness of breath

Feeling of choking

Chest pain

Heart palpitations, pounding heart, or rapid heartbeat

Nausea or abdominal pain

Dizziness or feeling faint

Fear of losing control

Fear of dying

Numbness or tingling sensations

Feelings of being detached from reality

Feelings of being detached from oneself

It is reported that the primary feature of panic disorder is panic attacks, followed by the presence one of the following:

Persistent anxiety about having more panic attacks

Excessive concern about the consequences of panic attacks

Changes in routine in order to avoid panic attacks.

These features are common with features of OCD. Some argue that panic disorders should be placed in the scope of OCD due to the similarities. It is reported that 6% of those with OCD have Panic Disorder. Both involve irrational thoughts and fears. Both are cyclic in nature, and panic disorder includes the obsession with future panic attacks.

The elaboration on panic disorder was included due to the applicable nature of the issue.

Perfectly in Control

Another disorder, related to OCD, is OCPD (Obsessive-Compulsive Personality Disorder). This disorder can cause relationship difficulties and depression. Signs of OCPD are as follows:

Perfectionism

Inflexibility

Preoccupation with details, rules, and lists

Reluctance to allow others to do things

Excessive devotion to work

Restricted expression of affection

Lack of generosity

Inability to throw things away (e.g., "pack rat")

One of the reported differences between OCD and OCPD is that behaviors in OCD are for the purpose of bringing relief, whereas in OCPD, the person gains enjoyment from his or her behaviors.

I see it. Now what?

If you have witnessed any of these traits, there is a possibility that your loved one has OCD, which also extends to the possibility of ROCD. Behaviors that appear obsessional, impulsive, or compulsive can suggest OCD. Obsessions can be about *anything*.

If you have witnessed a behavior that seems odd, or ob-

sessional (even slightly), you should to do research on the behavior. You can do this by browsing OCD message boards and forums (the best place to get answers from the sufferers, themselves). You can also do research through other sources online, such as encyclopedias. Information is plentiful, both electronically and in print.

If you feel confident that you have identified OCD tendencies in your partner, try to get your partner to a licensed professional for diagnosis. Some behaviors can be OCD-like, but diagnosed under other titles, such as OCPD. Do not assume that your partner has OCD until this has been confirmed by someone licensed to do so.

Chapter Three:

What causes Obsessive-Compulsive Disorder?

Obsessive-Compulsive Disorder is believed to be caused by a variety of circumstances, both environmental and physiological. This chapter covers *possible* causes for OCD, which is the foundation for ROCD.

The circumstances covered in this chapter are do not always cause OCD or related disorders. One can experience these events or circumstances without having or developing OCD.

Causes of OCD are not limited to those covered in this chapter. Additionally, while there are clear indicators that certain events or circumstances cause OCD, these are theoretical. Nothing has been proven to cause OCD. Circumstances and events in the lives of those with OCD are common in other cases, supporting the conclusion that such circumstances may cause the disorder.

The content of this chapter is for informational purposes only. Please consult a licensed professional for diagnostic or thera-

peutic advice.

The possible causes of OCD and related disorders are vast, and obscure. Scientists debate whether the causes are purely physical conditions of the brain, due to one's environment, or both.

If OCD goes untreated, it is usually a lifelong illness with cyclic worsening and improvement of symptoms. Obsessions and compulsions can only be reduced or eliminated with treatment. There is no cure for OCD, only ways to control it. OCD can be controlled to the point of insignificance.

It all started when...

There are debates about when OCD usually begins to appear in one's life. Some believe that most cases occur in the preteen and young adult years. Others believe most onsets occur between the mid- to late twenties and thirties.

A reason for this debate may be that OCD goes undiagnosed for an average of 17 years after first signs are apparent, thus the statistics used for these theories may be lacking accurate information.

Part One:

OCD and One's Environment

Environmental circumstances may link to causes of OCD. It is theorized that environmental circumstances may lead to developing OCD only if the person has a genetic or neurological predisposition to anxiety or obsessional behavior.

However, as with many other disorders, OCD can develop at any time in one's life. This suggests that chemical imbalance or other neurological problems may not be present at birth, but develop at a later time. This supports the possibility that OCD can develop due to one's environment, without the preexistence of neurological dysfunction.

For instance, if one experiences an emotionally traumatic event, such as rape, he or she can develop Post-Traumatic Stress Disorder, or PTSD, because of the brain's response to the event. Before the event the person may have had no problem with emotional modulation. PTSD is a common disorder among people who experience stressful events or circumstances. As much as 22% of PTSD sufferers have been diagnosed with OCD.

Some professionals claim that OCD can only develop due to neurological dysfunction. If that were true, certain therapies, such as Cognitive Behavioral Therapy (CBT), a method of behavioral “training”, would not be affective without medication. However, many sufferers control OCD using this therapy alone. That behavioral 'training' without medication can be effective in eliminating OCD supports the theory that environmental “training” may be responsible for the disorder.

Thanks, Mom (Dad)

OCD may be linked to parents for two reasons. These are genetics and upbringing. Some believe that OCD is a genetic condition transferred from parent to child. Genetic inheritance has not been proven or disqualified as a cause of OCD, and is a subject of debate among experts. Studies found that a person with OCD has a 25% chance of having a blood relative with the same disorder, and a 70% chance of identical twins sharing the disorder.

How one is raised may have significance in the development of OCD. Parenting choices and parental behavior have a significant impact on how a child develops both mentally and emotionally. This affects various areas of a child's development, including emotional expression, habituation, dealing with stress, and life philosophies. It is possible for a child of someone who has OCD to develop the disorder due to adopting the obsessive habits of the parent.

Oh, Merciful God

Some experts believe being raised in strict religious environments can have implications on developing OCD. Religions that include highly strict guidelines to living are more prominent in this circumstance. The conditioning or teaching that followers should try to be “perfect” can have significant implications in developing OCD. This conditioning affects the child's judgment of self, others, and the world.

Some religions teach social and, possibly familial separa-

tion. This can develop into OCD by the intensity in one's condition of judging others, or judging the correctness of others' actions. Intolerance, prejudice, and even the perceived worthlessness of another individual are all common developments due to upbringing in some religions. For a child, this can be disastrous in school environments, where peer interaction can be stressful.

The Pedestal

Some religions teach that those not of the same faith are "lesser beings", thus insignificant. "Why should I care about how you feel? You're dead anyway." and similar statements are made by some raised in these environments. This is can cause defects in perception of reality, personal significance, and other circumstances closely similar to traits of OCD.

Black Sheep

In separating from family or other loved ones, there is potential for confusion in children. For example, some religions teach that if a partner in a marriage separates from the faith, it is the member's duty to end the marriage. The impact this has on children of these relationships is significant. Not only is the child experiencing confusion about the separation, he or she may also receive instructions not to associate with the person. In some cases the child is even told not to love the "wayward" parent.

A typical child cannot handle the expectations of this en-

vironment. When the child feels affection for someone, he cannot purposefully change it without manipulation of some sort. This is often referred to as "brainwashing", and can result in significant anguish over the lost connection, and over love in general. This experience can either lead to unhealthy behaviors, such as deliberately avoiding love or close relationships out of self-defense, or developing unhealthy coping strategies, such as drug abuse.

With a Ten-Foot Pole

The perception that one should avoid developing loving feelings for another to avoid emotional catastrophe is one that is linked to disorders such as OCD. This includes sex addiction, in which some people will intentionally avoid emotionally intimate relationships. They will replace these with purely physical, impersonal ones. Emotional connections are crucial to a happy life. The lack of these connections often leads to loneliness, depression, self-hatred, and other unhealthy circumstances. Sex addiction, as well as others, may develop due to repeated efforts to provide distractions, fill emotional voids, and cover up subsequent emotions.

Unworthy

Another common result of strict religious upbringing is excessive guilt. The religion teaches that certain thoughts and behaviors decide the spiritual worth of an individual. As children, each of us are naturally susceptible to curiosity. In religious environments, certain subjects of this curiosity

are labeled as bad, providing grounds for the opinion that even thinking about a particular subject is unacceptable. The majority of these subjects are natural in childhood, and a child cannot typically "control" his or her curiosity. In these environments, a child is subject to feeling bad or guilty of religious crimes, although he or she is simply experiencing natural childhood. This sets the stage for self-hatred, social anxieties, extreme guilt, and traits similar to those of OCD and other disorders.

The Perfect Example

Strict religious upbringing can also include needing correctness in all choices. Pursuing the love and approval of their god, an individual is always seeking to make the right choices to avoid sinning, or otherwise earn the anger or disappointment of that god. Depending on the severity and persistence of indoctrination, this can develop into perfectionism which spills over into all areas of life. The fear of making mistakes can become so significant that it can develop into obsessive behavior.

Many disorders may trace back to strict religious indoctrination. These include the God Complex, magical thinking, belief in one's "divine purpose", and others. While having a belief or faith system is normal and can bring happiness in one's life without negative consequence, extremes can do more harm than good in the lives of some.

Tough Love

The relationship found between OCD and the strict nature of some religions applies to parenting practices unrelated to religion. The same features of correctness, standards of behavior, associations, and others are found in some parenting structures.

The religious fear of "God" is exchanged with the child's fear of Mom or Dad. The approval issues can be the same, and the child is subject to the same features of guilt and perfectionism in response to this environment.

When Structure Becomes Torture

A child growing up with a perfectionist parent can experience expectations beyond what is normal or healthy. The structure of the home environment is strict, and punishment for breaking the rules is excessive. The following is a account of one person's experience in such environment as a child, and the results:

> *"My ex-step-father was a Vietnam war veteran. My mother married him when I was about 4 years old. From that time, until she divorced him 7 years later, I was subject to a military-like environment in my home. My mother was not usually involved, because, since he could not work, she was always at work. This left me in his charge, which was devastating.*
>
> *I am pretty sure I have blocked out much of the experience, and truth be told, I don't know the accuracy of some of my memories, considering my age at the time. However, there are some things I remember very clearly.*

Much of my recollection of my childhood involves being locked in my bedroom. In thinking back, the majority of my memories are of moments that took place while I was isolated in my room. These are simply things that I did to pass the time, such as experimenting with the effects the Sun had on my eyesight due to over-exposure, determining the average length of a song on the radio, and other things one does when bored. I spent a lot of time alone and bored.

When locked in my room, I would lay down beside the door and watch through the crack between the floor and the door out of boredom. When I needed to go to the bathroom, getting attention usually required 10 to 15 minutes of repeated calls to him that I had to go. I would even see him walk by the door as I was calling out, not responding to me.

The experiences directly involving my step-father were usually troublesome. One, in particular, was what I encountered when asking for more water at supper. I was about 7 years old when this occurred. When I sat down to dinner, I noticed that my glass of water was low. I asked him if I could have more water. His response was that I should be happy with what I got. I was then punished by being forced to drink water, by the pitcher-full, until I threw up.

From that time, I never asked him for anything. I feared asking him for anything. I think this developed into a belief that I didn't deserve much, which had an effect on my self-esteem for much of my earlier years – even into adult-hood.

I recall another experience, wherein I snuck a cookie from the kitchen when no one was watching. I don't remember

how, but I got caught by my step-father. The punishment for sneaking one cookie was to continue the day with no additional meals, which included lunch and dinner.

When I was in 5th grade, I had my first experience with cigarettes. One afternoon after school, a kid had some and was allowing other kids to try smoking. I puffed at it once or twice, coughed profusely, and decided I had enough.

When I arrived home from school, I was approached by my step-father about being late. I was grounded at the time (I don't remember ever not *being grounded), and he was angry with me for hanging out after school.*

As he approached me, he smelled the cigarettes on my clothes, and asked me if I started smoking cigarettes "too". I replied, stating that I hadn't started smoking. I was slapped for lying to him, and sent to my room.

About an hour later, he came to my room and told me to follow him outside. There he had a pack of cigarettes resting on the front porch. He went to the garden faucet, turned on the water, and brought the hose toward me.

I was then commanded to eat each cigarette in the pack, using hose water to wash them down. Cigarette tobacco tastes awful, and just one was bad enough. But after about two hours, I had eaten all 20, and was intoxicated by the nicotine.

A short time later, back inside the house, I vomited, due to nicotine poison. My step-father made me clean it up, as part of my punishment. My mother, who had arrived home just prior to this, asked what was wrong. I was not able to tell her the whole truth, for fear of what my step-father

would do. I only told her I must've eaten something bad.

Any mistake or misbehavior was often met with excessive punishment. This included holding dictionaries on outstretched hands until the pain in my arms became unbearable. If my arms dropped, this was also met with punishment. Another was kneeling on uncooked rice which occasionally resulted in bleeding sores on my knees. There was significant corporal punishment, such as spanking with a belt, wooden spoon, or his hand. I was punched a few times, and strangled once. It was common to go without a meal or two.

In looking back, I realize that this was abuse. I can also see how this affected my sense of self-worth, social development, and many other things. In his view, locking me in my room was part of his military standards of reform. I was in isolation. I was taught that mistakes and failure to adhere to his strict structure would be met with severe consequences.

I was once removed from my home by child protective services, when teachers from my school recognized strange behavior, which resulted in the nurse checking me and finding bruises on my body.

It may be hard for people with no experience with child abuse to understand this, but at the time, I saw nothing wrong with what was happening to me. I thought this was how everyone was raised.

Although my mother eventually caught onto his abuse, and subsequently left him, the effects of my environment stayed, and developed into a variety of disorders. I was di-

agnosed with ADHD, later with Oppositional Defiant Disorder. Although undiagnosed with it during those times, I am positive that this also created a predisposition to major depression, social anxiety, post-traumatic stress disorder, general anxiety disorder and other problems that have occurred throughout my life since. I believe these catalyzed into OCD. These developed into magical thinking, intrusive thoughts, skin picking, and Body Dysmorphia. I also developed panic attacks, which included heart pounding or racing and shortness of breath, adrenal fatigue, and hypothyroidism.

I think my OCD developed as I started engaging in practices that I believed helped me cope with major stressors in my life. It seemed that with my mind being distracted with my obsessions, it relieved the real pain and helped me get through. I don't think I ever learned healthy coping habits for stress, and my mind just started creating its own."

The forgoing describes a circumstance that is troubling, as child abuse was present. This may have increased susceptibility to mental illness. It explains how a parent's choices in upbringing impacts the child's development, all the way into adulthood. This also shows how OCD may be a result of other typically unrelated illnesses.

There was also a clear example of lack of affection or compassion in this person's childhood, which is common for OCD sufferers.

Your #1 Fan

Strictness in parental upbringing is not exclusive to abuse cases. Perfection in any form can be inductive to OCD, such as in chores, childhood sports, school grades, beauty pageants, or other activities that involve performance. Children in this circumstance can lack healthy social development, and other crucial life skills, due to excessive preoccupation with these kinds of activities. The parent pushes excessively for perfection or success, and the child strives to please. The goal for the child is to make the parent happy, either out of fear or the quest for approval. This can lead to OCD by creating an expectation of perfection in all areas of life for the child.

Under My Wing

Overprotective parenting is common in OCD cases. It is considered to be a possible cause of the disorder, as well as having significance in other mental illnesses.

An example of overprotective parenting is when a parent restricts the child from doing things that could put the child in danger. Beyond normal parenting practices, this refers to the refusal of activities such as riding a bicycle or playing at a park, due to paranoia. The parent has abnormal fears of catastrophe, such as child abduction. Normal occurrences such as falling and scraping a knee while playing is abnormally feared and risks avoided.

Your Wish is My Command

Overprotection also includes circumstances where the

child is coddled. Meals and other daily routines revolve around the child's wishes. All plans adjust to suit the child's preferences.

Children in this environment are often “babied”. The parent shows excessive sympathy to the child, and the child develops the idea that he or she is the center of all things. This can go as far as one parent arguing with the other, in front of the child, over issues such as whether the child, who is old enough to do so, should have to pick up his or her toys.

Another common practice is the parent sleeping with the child, or allowing the child to sleep in his or her bed. This happens more often or at a much later age than is considered healthy or normal.

Parents will often expect others to treat the child in the same way, such as school faculty or neighbors. The parent may seek special treatment for the child. He or she feels the child should be treated differently than other children because the child is “special,”, when, in fact, the child is not so different from other children.

Chores are either not required, or excessively rewarded. Often, the parent does everything for the child, as though the parent is the servant.

Too Much of a Good Thing

This environment can result in the child absorbing the paranoid fears of the parent and abnormal preoccupation with “self”. This can create the self-perception that the child

is superior to others, and other unrealistic ideas. In addition, this kind of parenting can be damaging as it fails to properly prepare the child for real world circumstances that he or she will inevitably experience.

This often results in unpreparedness in areas including social interaction, cooperative relationships, and self-reliance. Common results, such as social rejection, incapacity to care for one's self, repeated failed romantic relationships, and an inability to uphold employment may lead to a series of psychological problems, such as anxiety disorders, depression, and OCD.

The Usual Suspects

Environmental causes of OCD are not limited to these circumstances. They include issues involving siblings, extended family, and other people in close to the child. Physical, emotional, and sexual abuse may develop anxiety or depressive disorders. Other circumstances such as neglect, sibling rivalry, fighting between parents, parental alienation, physical or mental disabilities, academic or extracurricular pressure and social problems can also have an impact on the potential to develop disorders.

Besides long-term circumstances, single events that take place in a child's life may precipitate OCD. These include, but are not limited to the following:

Death of a loved one, such as a parent or sibling

P**arents divorcing**

Relocation

Changing schools

Birth of a new sibling

Parents' preoccupation (new baby or other sibling)

Natural disaster

Accident (e.g., vehicle, pedestrian, or home fire)

Crime (e.g., kidnapping, rape, or assault)

Age is but a Number

These and similarly upsetting events that can cause OCD and other disorders are not exclusive to children. Adults may also develop the disorder as a result of events or environments that can be emotionally stressful. These include, but are not limited to the following:

Death of a loved one (e.g., child, parent, significant other)

Illness of self or loved one

Getting married

Having a baby

Postpartum

Spousal relocation (e.g., employment, military assignment)

Loss of relationship (e.g., divorce, separation, break up)

Romantic rejection (unrequited romantic interest)

Abuse by spouse/significant other

Divorce-related problems (e.g., loss of custody or parental alienation)

Children leaving the home (e.g., college or moving into their own place)

Crimes involving children
Work-related problems
Loss of employment
Financial distress
Social problems (e.g., racism, homosexual abuse, or abuse related to physical or mental disabilities)
Legal problems
Relocation
Natural disaster
Accident (e.g., vehicle, pedestrian, or home fire)
Crime (e.g., robbery, rape, assault, identity theft, or kidnapping)
Drug addiction

Follow the Leader

OCD may be a result of other disorders, and is often found to accompany them. Other mental illnesses, such as depression, paranoid disorders, and other anxiety-related problems may exist before the onset of OCD. Without treatment, additional mental illness may develop, like a snowball effect.

For example, social ridiculing can lead to depression, which leads to social anxiety. The social anxiety develops into panic disorder. The panic disorder develops into obsessional behavior, which then leads to OCD.

The following are statistics for mental illnesses accompanying OCD:

- **Two-thirds** of OCD patients have depression.
- Up to **70%** of OCD patients have Major Depres-

sive Disorder.

- Up to **35%** of Bipolar Disorder patients have OCD.
- Up to **22%** of PTSD patients have OCD.
- **40%** of those with Tourette's Disorder have OCD.
- OCD patients have a **35%** lifetime incidence of Panic Disorder.
- **20%** of OCD patients have Generalized Anxiety Disorder.
- **24%** of OCD patients have Social Phobia or other phobias.
- **25%** of OCD patients have or have had ADHD.

Part Two:

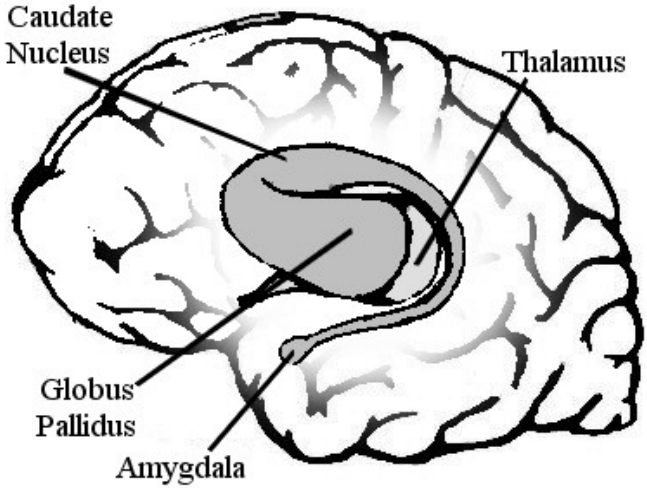
OCD on the Brain?

Neurological considerations are thought to have a part in developing OCD. These are typically chemical imbalances, and physical dysfunction. This section will cover the neurological issues most commonly associated with OCD.

The parts of the brain most commonly associated with OCD are the basal ganglia, frontal lobe, and limbic system.

Basal Ganglia

Basal ganglia refers to a group of parts located in the middle of the brain. The circumstances that lead to the theory that dysfunction in the basal ganglia causes OCD are complex, as are the types of dysfunction and how they impact behaviors.



The basal ganglia are responsible for instinctive responses to the environment, and is referred to as the primitive

part of the brain. This area processes information received from the environment, decides risks, and develops a response based on instinctive judgment. This is applicable to routines such as driving, locking a door, or the measure of a step when walking up steps. The basal ganglia are responsible for telling us when and how something needs to be done, and when it *is* done. For example, it is responsible for telling you that you are thirsty, telling you to drink something, and telling you when you've had enough to drink.

There are a variety of areas where this is applicable, which include motor function, bodily-function regulation, cognition, emotions, habit, and learning.

In OCD, the hormone and neurotransmitter of primary interest in this part of the brain is dopamine. Dopamine is responsible for the brain's judgment of what is good or bad.

For example, the habit of locking the front door before bed starts here. The basal ganglia works with memory, so it remembers that you feel good (dopamine) when you lock the door. It sends a signal to go and lock the door before bed. The memory part of this may come from a previous experience of going to bed without locking the door, which led to bad feelings (dopamine), which caused you to get up and lock the door.

The brain remembers the relief you felt when you locked the door, and stores the experience in instinctive memory. The more times this occurs and creates good feelings, the stronger the instinct grows, and it eventually becomes a habit. This is relative to the learning association with this part of the brain. As it remembers things that make you feel good, it also remembers things that make you feel bad, and

develops instinctive responses to those circumstances.

The basal ganglia are our autopilot. The processes are instant, and occur without thought. For example, when you lock a door, you don't think about how you have to turn the lock. You just do it.

It is also the part that gives the signal to remove your hand from something hot, or how long to 'sink' while sitting down. Many people have experienced the feeling surprise when going to sit down in a chair, and actually *falling* because the chair was lower or further away than they "thought". Though often used, "thought" is not an appropriate word, as there was actually no conscious choice involved, rather an instinctual estimation. That is an example of instinctual "assuming" in the basal ganglia.

Dysfunction in this part of the brain can lead to many problems. With OCD, the primary interest is how dopamine affects the work of the basal ganglia, and how normal function is altered.

Hyperactivity in the basal ganglia is often present when observing the brain of an OCD sufferer. There are several theories about what this causes. A popular theory is the function of "knowing" when to stop a particular behavior is impaired.

For instance, when washing his or her hands, a person normally has no problem knowing when the hands are clean and he or she can stop. In cases of dysfunction, the person might wash his or her hands for an excessive duration, due to a lack of the signal that the work is done.

The absence or impairment of the 'stopping' function can create obsessive or compulsive behaviors, as a person may

not know when “enough is enough”.

Dysfunction in this part of the brain can also cause repetitive action, as well as creating a false sense of need for certain behaviors, such as needing to wash your hands when they are already clean.

Another, and equally popular theory is that the level of dopamine in the basal ganglia is the key factor in OCD. Dopamine is responsible for telling us what we do and don't like.

Dopamine is a neurotransmitter that is released to brain receptors in order to regulate response. It is dysfunctional absorption by the receptors that is thought to be a culprit for OCD.

In under-absorption, the receptors don't absorb enough dopamine. In over-absorption, the receptors take more of the chemical than is normal.

The level of dopamine absorbed by receptors during an experience will affect whether the basal ganglia labels the information as good or bad. This information is stored into memory, and used the next time one is in the same or similar circumstances.

Over-absorption of dopamine can result in a person being particularly good at making rewarding choices. However, he or she will not fair so well at *avoiding* negative ones.

In contrast, under-absorption of the hormone will cause a person to be good at avoiding things that result in bad feelings, but he or she will not do so well with choosing rewarding options.

This may reflect as a personality trait in which a person appears negative, or even paranoid of bad things happen-

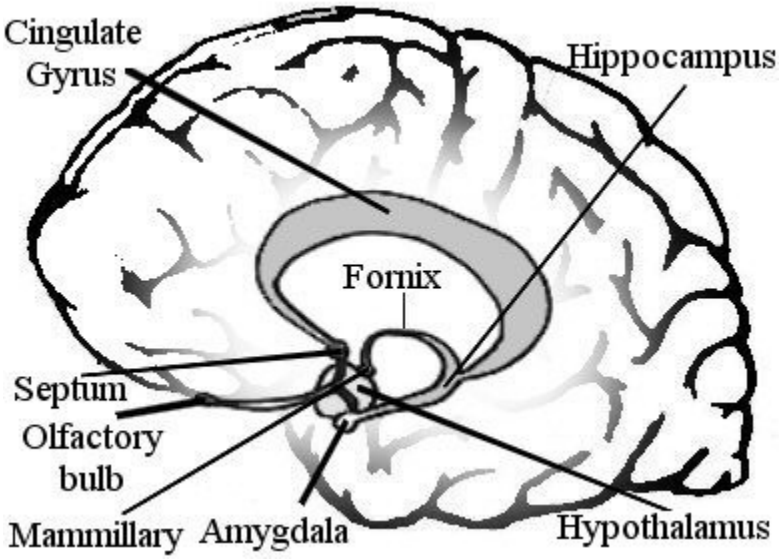
ing, because bad feelings are all he or she learns from. Under-absorption of dopamine limits the amount of pleasure one can get from rewarding experiences, thus the basal ganglia doesn't "remember" these so well. This can create preoccupation with 'threats', which is characteristic of OCD.

Dysfunction of the basal ganglia is also associated with other conditions, including the following:

Attention Deficit Hyperactivity Disorder
Cerebral Palsy
Tourette's Syndrome
Parkinson's Disease
Stuttering
PAP

Limbic System

The limbic system communicates with the basal ganglia, and is partially responsible for the results of basal ganglia-related behaviors.



The limbic system has many functions, including emotion and memory. Fear is associated with the amygdala, and the hypothalamus is associated with memory. Both are found in the limbic system. This system works to receive information, associate it with memory, and create an emotional response. It controls mood, emotional reactions, memory association, and sensory association.

The primary association between the limbic system and theorized causes of OCD is emotion, or specifically, fear. The amygdala is the subject of this theory. The amygdala creates fear emotions, causing the justification for defensive response in the basal ganglia. Overactivity in the amygdala can result in excessive fear, leading to excessive defense responses.

Besides association with fear, other possible circumstances theorized to cause OCD is a dysfunction in the

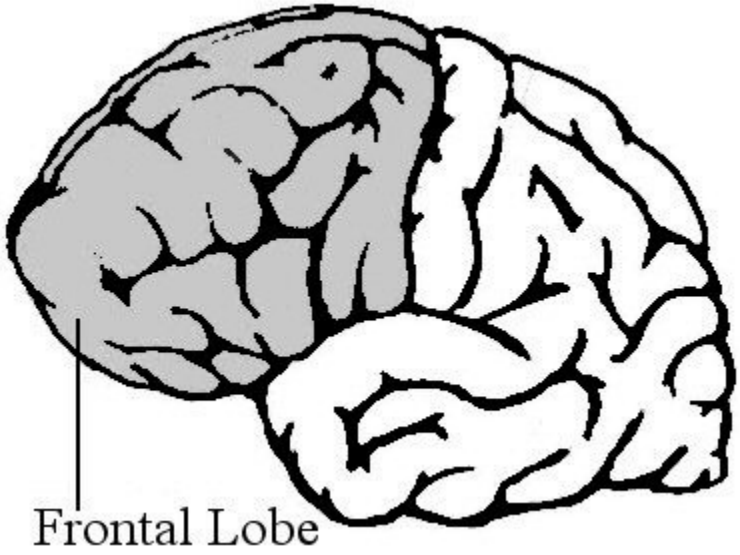
sending of signals.

The cingulum, or belt, is the matter on which the parts of the basal ganglia and the limbic system are located and connected. The cingulum is responsible for carrying messages to and from other parts of this structure.

If the cingulum isn't working properly, it can create communication problems between emotion and instinctive response, present environment and learned reaction (instincts created by memory), and other issues. Dysfunction can mean miscommunication of signals the brain needs to operate normally in the environment.

Frontal Lobe

The frontal lobe is at the front of, and occupies about one-third of the brain.



Where the basal ganglia handles what we do instinctively, the frontal lobe is responsible for what we do on purpose. This part of the brain handles organizing and planning. It regulates the decisions we make, problem solving, purposeful behaviors, emotions, and controls our judgments and impulses.

The frontal lobe works in line with the basal ganglia, as it is from here that the basal ganglia get information. The frontal lobe "sees" the environment, and sends the information to the basal ganglia. The basal ganglia evaluate the environment, and send messages back to the frontal lobe, suggesting an appropriate reaction based on instinctual memory.

The frontal lobe is where rational thought takes place. To be more specific, this is where people have the choice to respond instinctively, or logically. The function of the frontal lobe allows us to theorize potential outcomes of given actions. Dopamine is present, and plays an important role here, as well as in the basal ganglia. However, our inclinations based on the 'good' and 'bad' messages from dopamine are handled differently in the frontal lobe.

For instance, the basal ganglia tells us what we would *rather* be doing, based on immediate gratification. The frontal lobe tells us what we should be doing, based on rationalization.

An example of this is the desire to watch a television show that is playing at a particular time. The basal ganglia remembers that watching the show 'feels good', and sends the signal that one “wants” to do that. The frontal lobe receives the message, evaluates it by cross-referencing it with the knowledge that the lawn must be mowed before dusk, which would cause the person to miss the television program.

It then provides alternatives. These are to not mow the lawn and watch the program (inclination of the basal ganglia) or miss the program and do the chore. The frontal lobe analyzes possibilities by comparing “good” factors (e.g, entertainment) versus “bad” factors, (e.g., confrontation with spouse for not mowing the lawn). After this comparison process is finished, a decision is made, and the message sent.

Dysfunction of the frontal lobe can cause this logical reasoning process to fail. In OCD, behaviors and obsessions

are irrational and excessive, which indicates a potential for dysfunction in this part of the brain.

Chemical Imbalances

The term "chemical imbalance" refers to the absorption of hormones or neurotransmitters that is either to too much, or too little.

As previously discussed in this part, dopamine is considered in chemical imbalances associated with OCD. Another hormone often linked to OCD is serotonin.

Serotonin

Serotonin is a chemical neurotransmitter that is responsible for transmission of emotional modulation signals, and those associated with certainty and completion. Serotonin affects behaviors motivated by uncomfortable feelings.

Serotonin is the "It's Okay" chemical of the brain, effecting feelings of content and safety. This is different from dopamine, whereas dopamine is the "That Feels Good" chemical.

Under normal operation, it prevents us from overreacting, and serves as a defense against unnecessary stress. As with dopamine, an imbalance in receptor absorption of serotonin results in extremes. Over-absorption results in abnormal tolerance to discomfort, which results in abnormally low defense responses.

This can be harmful, as it can cause the brain to be unresponsive to real danger. Under normal circumstances, danger is recognized through memory. The message of danger

recognition is sent to the fear factory (amygdala) which then sends the message of fear to the reaction "hub" (basal ganglia), where reactive defenses are created. These are sent to the frontal lobe, and a calculated defense is developed. Serotonin is key to the transmission of the signals involved in this process. (This is a generalization of how this messaging system works. The exact manner is far more complex.)

Over-absorption of serotonin would suggest that danger is not there, or isn't "as bad" as it really is. This characteristic can be associated with people who have a "devil-may-care" personality, in which they tend to get into trouble due to lack of environmental awareness.

On the other side is the under-absorption problem, which is primarily associated with OCD. As over-absorption creates excessive calm, under-absorption creates excessive reaction to stress. The brain is not able to distinguish between what is a real threat and what is created by unregulated fear components. Therefore, a person would have excessive emotional reactions to circumstances that would normally be regarded as insignificant.

This can cause anxiety and obsessional behavior, characteristic of OCD. The sufferer has no ability to identify the difference between a real and "imagined" threat, which leads to an inability to feel "safe", which leads to excessive preoccupation with defense (obsessiveness).

The Others

Aside from potential causes previously covered in this chapter, there are more theories, which include over or underdeveloped parts of the brain, brain injury, bacterial in-

fections, and others. Along with serotonin and dopamine, other neurotransmitters, such as noreprinephrine and GABA, are theorized by some to associate with OCD. Additionally, some believe that circumstances of a brain substance called endo-cannabinoid, or the receptors associated with this may be a consideration.

How can one know?

Considering the variety of issues and elements involved, it is easy to see why professionals are unable to decide the true cause of OCD. Perhaps there isn't just one cause, but many, just as lung cancer is not only caused by smoking. Perhaps it is a combination of circumstances. One thing is certain: No one knows why a particular person has OCD, they can only theorize.

Chapter Four:

Don't be a Victim

People in relationships with ROCD sufferers are subject to more criticism and expectations of perfection than normal.

This chapter will help partners understand and avoid dangers, and to create strategies for protecting themselves from becoming victims of the emotional chaos often found in Relationship Obsessive-Compulsive Disorder.

Don't let it get you, too.

If one chooses to remain in a relationship with a partner who has ROCD, he or she will need to develop healthy practices for avoiding the possibility of becoming a sufferer themselves.

The previous chapter covered events and circumstances that may lead to mental illness. These apply to the stress one can experience in an ROCD relationship. This means that you will have to take extra care to guard yourself against developing of your own mental illness.

Others in relationships with OCD sufferers may develop the same behaviors. Although this was previously referred to in child-parent relationships, this also applies to romantic ones.

Humans are emotional creatures. Criticism from those you love is naturally taken more seriously than that from others. This is especially true in romantic relationships. It is not abnormal for people to experience feelings of self-doubt in response to criticizing statements made by partners. In ROCD, self-doubt can be a regular occurrence, due to abnormal frequency of criticism and often hearing that your partner does not love you. This may develop into bigger problems.

Because Love Said So

Love is an interesting thing. Though no one knows exactly what it is or how it works, we know that it can cause us to behave in ways in which we would avoid in other circumstances. Things we do for love are not always rational

or healthy.

We have little control over love. We have a difficult time telling ourselves who and when to love, and when to stop loving. If we could control this, there would be a significant decrease in music and film production, among other media. Poetry may all but cease to exist.

In ROCD, love is the primary reason someone stays with the sufferer, despite how painful it may be. Love creates toleration. If love weren't present, a person would likely leave the relationship, due to intolerance of its cyclic "loves-me-loves-me-not" nature.

Tolerance is not the only thing love creates. Love also has a way of putting "blinders" on people. Where in normal circumstances we can easily recognize unhealthy or illogical behavior, love can make us see sense in it and even develop those behaviors ourselves. This is a danger in ROCD relationships.

Devoted and understanding partners may unknowingly create unhealthy circumstances both for the sufferer and themselves. In one way, they may enable the sufferer's condition by accepting, or even supporting the behaviors. In other ways, they may actually start doing these themselves.

For example, the following is an account of a circumstance in which a sufferer's behavior developed into obsessional thinking in the partner.

"We were sitting outside, having a drink and enjoying a summer day, when my partner informed me that I had large pores on my nose. I knew I had visible pores, but I had never really given it much thought. I always had good hygiene habits, and considered

my pore appearance as just a part of "me".

However, his statement bothered me, mostly because I knew by then that when he said things like that, it usually meant that he viewed it as a significant flaw. Flaws had a tendency to be used as a reason to break up with me, so I would freak out a little when he would address them.

This caused me to spend an abnormal amount of time in the bathroom that evening, washing my face and examining my pores. But it didn't end with that evening. Later I went shopping looking for products that would reduce the appearance of my pores. I ended up purchasing what many would consider an unreasonable amount of skin care products.

It was this experience that was behind the development of an unusual preoccupation with my complexion. It is difficult, if not impossible, to reduce the size of pores. This created a need for more makeup to cover them, and an increased awareness of how close people got to my face. Before this I would get pimples here and there, and would have normal frustration with it, but nothing major.

My pore-cleansing process developed into repeated nose-squeezing, used to push the dirt out. After which, I would get peeling, because I had damaged the outer layer of skin. This didn't stop me. At the young age of 29, I started purchasing chemical peels in hopes of results. My excessive preoccupation with my nose pores never reached OCD level, but it was what I consider slightly obsessional. All because my ROCD-boyfriend pointed them out. If it had been anyone else, I wouldn't have taken it so seriously.

At the time I wasn't aware of the term "ROCD", but I was certainly aware of my boyfriend's tendencies. When he pointed

out something wrong, my response was always to try to fix it, because if I didn't, he might break up with me".

This is a clear example of how ROCD can affect partners. A person may develop OCD-like traits, due to constant exposure to someone else's OCD. In ROCD, the sufferer's preoccupation with flaws can cause the partner to develop the same preoccupation. In the example, the trait developed was relative to Body Dysmorphia, in which one believes that flaws are excessive, and develops an unrealistic idea that others pay much attention to these flaws.

OCD is not the only disorder that may develop because of these relationships. Self-esteem is the primary target for damage from ROCD, due to repeated criticism and cyclic revocation of love. This may result in depression, anxiety, and other unhealthy conditions.

Too Little, Too Late

It is common, yet unfortunate, for people to sacrifice their own needs "in the name of love". This is not healthy, and can have disastrous results. Despite the belief that this sacrifice deserves some sort of "honor", it is a mistake that often has long-term consequences. It is not selfish to put one's own emotional health needs first. Contrarily, it is wise to do so.

If you have already developed emotional problems due to experiences an ROCD relationship has created, it is important to get help *now*. If this problem continues to be subject to the cause and goes untreated, it can develop into real disorders, requiring more intense work to overcome. Addi-

tionally, such disorders may impact the quality of other areas of your life. They can affect your ability to maintain healthy social relationships, employment, and general happiness. It is your responsibility to others, such as your children (if applicable), to get and stay well.

You are probably reading this book because you want to help your partner and save your relationship. It is important that you understand that if you are not healthy, you can be of little help to another unhealthy person. Should this be applicable to you, your first step in the effort to overcome ROCD *together,* is to get help for *you* first.

Knowing You

In ROCD relationships, partners are likely to hear many claims about themselves that are not true, not important, or exaggerated versions of the truth. One needs to preserve a realistic perception of the self, when facing such "charges". This means knowing yourself well enough to know when a description of you is or isn't accurate.

For example, if you're told that your personality is not socially "correct", yet you have many friends or have not experienced any significant social problems, this declaration should not be taken seriously. This is often difficult because it is normal for a person to listen to his or her partner's opinions and consider them. However, with ROCD, one is not in a "normal" relationship.

Instead of taking remarks personally, or worse, allowing yourself to consider the possibility that these are true, try ignoring them. You know better, so there is no reason to

give it undue consideration. Avoid allowing yourself to get upset, as this not only helps you, it is also a part of helping your partner overcome ROCD. If you respond in a way that confirms your partner's idea that something is wrong with you, even by making fair excuses for yourself, you are giving strength to his or her doubts. The best thing to do is to let these go in one ear, and out the other.

The suggestion to ignore remarks made by your partner is not one to stop respecting your partner's opinions. It is to learn that certain behaviors are a product of his or her ROCD, and it is the ROCD that should not be respected. ROCD doesn't know the real you, and therefore has no authority to judge you.

If it helps, think of ROCD as an occasional third person in your relationship, who shows up and tries to get your partner to leave you. You have to live with ROCD for a while, because overcoming it usually doesn't happen quickly. Since you have no power to make it go away, it's better to just ignore it, and not let it get you upset.

The death of the logical argument

It is natural to want to argue with your partner, and try to get them to see how illogical their thoughts or behaviors are. Unfortunately, this is usually a lost cause, as it is all but impossible to rationalize with something that isn't logical, such as OCD. Try as you might, ROCD has taken over and convinced your partner that what he or she believes is real. One can rarely successfully argue with another's belief.

However, giving up and letting ROCD have its way is not

a good alternative. You should avoid giving theses thoughts or behaviors any weight. Conceding for the purpose of avoiding confrontation, or exhaustion with the debate, is not advised.

Be careful not to let his or her beliefs make you doubt your own knowledge. You know the subjects of his or her obsessions are either minute or nonexistent, and what he or she believes is not based on reality. The rigidity of these beliefs may make you question whether it is *you* that is not seeing things clearly. This is not the case, and you should not allow this to happen to you.

A good way to deal with this is by agreeing to disagree. Tell your partner that you do not agree with what he or she is saying, but don't argue with them. Another alternative is to make a joke out of it, while avoiding sarcastic tones, of course. “What do you mean I'm not perfect? Of course I'm perfect.” This way you have avoided confirming your partner's beliefs, and stopped the situation from perpetuating into an argument no one can win.

Confessional Closed

Once a person has been in a relationship for a significant amount of time, he or she often develops the ability to predict partner's moods and tendencies. This is equally true with ROCD. If you have experienced a few cycles, you should be able to spot when one is coming. This is when you should start preparing yourself for the results. This includes getting ready to turn down your partner's attempts at confessing his or her doubts, and the flaws that cause these doubts.

You don't need to hear those things. Additionally, some professionals believe that being a willing audience to the confessions of an OCD sufferer is enabling the compulsion. You can respond to your partner's confessions by simply saying, “No. I will not listen to you tell me what you think is wrong with me, or our relationship. It's not true, and I don't need to hear it.” This may sound mean, but “tough love” is part of helping your partner beat ROCD, as well as preserving your self-confidence.

It's not YOU

Your partnership started for a reason. You and your partner liked each other enough to deepen your relationship. It is safe to assume that your partner found you to be enjoyable, like-able, love-able, and “mate material”. Unless you were lying, or hiding certain elements of your personality that may have caused your partner to lose affection for you, it is probable that those things have not changed, and are still present in your relationship.

That you are the subject of your partner's negative obsessions could also be an indicator of just how important you are to them. OCD sufferers often develop obsessions with those closest and most important to them. Remember that obsessions usually develop in defense of anxiety.

Anxiety in intimate relationships usually comes from a person's fear of loss or other painful experience. It's possible your partner obsesses about substantiating your relationship because he or she does not trust that they are “safe” in it. Safety is to be invulnerable to threats.

That vulnerability may be what drives your partner's ROCD. Consider why someone would worry over whether they are with the right partner. There is a possibility that this person has been significantly hurt over the loss of a previous relationship that seemed so "right". This may have caused the development of abnormal or irrational worries that this will occur in your relationship. An ROCD sufferer may question their judgment of the current relationship because their previous judgments were wrong, and resulted in emotional suffering.

Considering these possibilities, it is reasonable to assume that you are a good partner, and your partner loves you. Unfortunately, his or her ROCD doesn't want that, and works against it.

This may be why commitment is so difficult for ROCD sufferers. Theoretically, to commit is to lock the "emergency exit", and make them more vulnerable to the threats that inspire their obsessions.

You don't need to change. You attracted your partner to you, which means that he or she is probably still attracted to you. Evidence of this is there when your partner is "normal" and is able to show affection toward you. Your character and physical appearance don't change on a regular basis, and have nothing to do with the onset of spikes. These are purely in your partner's mind.

In normal cases, people usually know how they feel, and don't spend significant amounts of time going over the negatives of a partnership for substantiation. The cyclic nature of going back and forth between love or attraction isn't normal, either. A person doesn't normally feel love for someone

one week, not the next, and love again the third, without a significant probability that this is caused by problems unassociated with the relationship or the partner.

In ROCD, the sufferer is often unable to recognize that lowered intensity of "in-love" feelings is normal. They can't conceive that these feelings are usually at their peak during the first part of a relationship, but naturally level-out eventually.

It is also normal for these feelings to come and go throughout the life of a relationship. The ROCD sufferer doesn't understand that magnetic feelings not being present at moment does not mean that they will not return. Additionally, the very process of questioning love often has the result of reducing the appearance of the emotion, as doubts are strengthened by the amount of attention given to them.

What this all boils down to is that this is not your fault, or your problem. You did not create your partner's ROCD. There is nothing significantly wrong with you. You don't need to change who you are to make your partner love you. You're fine the way you are, and if your partner didn't have ROCD, he or she would be able see that.

When the going gets tough

Enduring the pressure that ROCD can bring to relationships is difficult, and at times, unbearable. To keep your patience in hard times, developing your own defense practices is important. You can't expect to have an endless supply of tolerance. If you do nothing to preserve balance, your emotional responses may be regrettable, or worse, escalate the

problem.

Entering an emotional dispute with your partner, or responding to criticism in kind can only result in worsening the effects of ROCD. Getting angry is natural and is to be expected. However, letting the anger get to a point that it causes you to behave in ways you normally would not is unhealthy for you, your relationship, and for ROCD.

Your partner's ROCD is causing him or her to doubt your relationship. If, in heated moments, the “ugly” side of your nature (everyone has one) is displayed, this can only work to strengthen your partner's doubts. He or she is already wondering if you are right for them. Imagine what happens to them when you appear before them, yelling or otherwise losing your temper. You are basically sealing their case against you, even though it is this “case” that caused you to get angry and react.

Gaging your level of patience is a helpful tool in avoiding unnecessary problems. By recognizing that you are about to reach the limit of your tolerance, you allow yourself the chance to take decisive action in avoiding blowups. Signs that you're developing a “short fuse” include, but are not limited to the following:

Physical tension

Emotional tension

Irritability

Depressed mood

Inability to concentrate

Over-reacting to minor problems

Feeling like you don't “like” your partner

Trouble dealing with other stress, such as work

If you start feeling any of these, it is a signal that you need a "time-out" to get yourself back into a healthy state of mind. There are a variety of ways you can help yourself to maintain emotional balance. These should be activities that effect tension release, whether they are healthy outlets for aggression or more tranquil occupations. Some examples are as follows.

Letting off Steam

- Physical sports or activities, such as tennis, basketball, racquetball, weight-lifting, running or other cardiological exercising, or "quality time" with a punching bag
- Listening to loud music (practice safety when using headphones)
- Uninhibited loud singing
- Going where you can be alone and yelling or screaming at will. (Preferably away from residential or fairly populated areas.)

Be sure that your choice of outlets are safe, not only for yourself, but for others. Avoid activities such as fast driving, substance abuse, or other unsafe or unhealthy practices.

Inspiring Tranquility

- Taking a walk (e.g., park, nature path or along a beach)

- Taking a low-paced scenic drive (without the pressure of having a destination)
- Listening to music that inspires good feelings and calm
- Meditating
- Breathing exercises
- Yoga
- Gardening
- Creative projects or activities (e.g., playing an instrument or painting)
- Reading a book (avoid horror or drama subjects)
- Feeding birds
- Getting a massage or time at a day spa
- Spending time outside on a sunny day (carry sunblock)

Although you may enjoy things such as reading horror books, or similarly stimulating activities, the point of relaxing is to reduce mental tension. This means not provoking anxious feelings. Things that inspire anticipation or anxiousness are counterproductive to the goal. Although it may not be stressful, it is still a mental "winding up", when it should be a release.

In the heat of the moment

When an argument or confrontation is either imminent, or has already started, you should get yourself out of the

situation quickly. This means walking away, hanging up the phone, or otherwise extracting yourself from the circumstance. This doesn't mean just hanging up or walking out without warning. As calmly as possible, state that you need to end the conversation, and that you'll talk to your partner later.

Avoid outbursts that may later be regretted, such as “You're impossible!”, “You're crazy!”, or “You're driving me nuts!”. These are unproductive and offensive, and only work to make problems worse. You're goal should be to get past the cycle unharmed, and without hurting your partner.

Ending the conversation may be unwelcomed by your partner, however it is a part of taking care of yourself. Stress and anxiety are not healthy. Don't allow yourself to be captive in this environment. You cannot control your partner, but you can control yourself. Use that control to stop a bad situation from getting worse.

Family and Friends

family and friends are typically the first to turn to when one needs emotional support. When dealing with your partner's ROCD, getting support from loved ones may not be as easy as would other issues. Your loved ones may not understand ROCD, and they may not understand why you would choose to stay in a relationship that causes you so much grief.

When seeking the support of your friends and loved ones, you should first do your best to help them understand ROCD, and OCD in general. You could consider giving

them this book, or suggesting that they get a copy.

Once your loved ones understand the disorder, and they understand what you are dealing with, you may be able to get positive support. However, loved ones may remain unsupportive, regardless of the level of understanding. This is because some may have the opinion that, no matter how innocent your partner may be at the heart of things, he or she is still hurting you.

No one will truly understand the depth of your love for, and commitment to your partner. This can only be speculated, because no one else feels for your partner the way that you do. The most you can do is your best in explaining your position.

Focus your efforts on those you feel would more likely understand and be supportive. Don't waste your efforts on those who will be negative influences on your experience. This doesn't suggest that they don't have your best interests at heart. Contrarily, they are usually this way because they care for you very much, and don't want to see you hurt, no matter the reason or excuse. Regardless, you should only involve those that will be there for you the way that you need them to be.

The goal is to help your partner beat ROCD, and, ultimately, save the relationship. You should only involve others who would support that goal. After you've helped them understand ROCD, you should help them to know how to be supportive. They may not know what you need.

One thing that you don't need is advice on how to deal with your partner from those unfamiliar or inexperienced with ROCD. This is a common problem with loved ones.

They want to help, so they give you advice. Unfortunately, their advice comes from their knowledge of *normal* circumstances or those that are handled with logic. ROCD is different, therefore the strategies for dealing with it should be as well.

You can tell your loved ones that you are not looking for advice. This may present them with either relief or frustration, but it makes it clear that this does not help you. You also need to clarify what *does* help.

It helps to just have someone to vent to, who can hear you, let you cry, and even hold you in silence when you need it. Release is therapeutic, and getting your frustrations out of your mind and into the air can bring relief. If your loved one does respond to you, it should be in a way that is sympathetic or empathetic, but not in frustration.

It does not help you to have someone else express anger or frustration toward that which you are committed to working out. Statements such as "That jerk!" or "I don't know why you put up with it" are not helpful. Simple remarks, such as "I'm sorry you are going through this" or "I hope it gets better soon" are good, supportive words that you will likely need to hear occasionally.

You have a responsibility in making sure that others are able to *stay* supportive. Going to a loved one and complaining about how mean your partner is acting, or calling him or her names is not going to work out well if you want support in keeping the relationship.

How you describe your partner is how your loved ones will view him or her. Once you have given them the impression that your partner is a mean person, you will not be

able to take it back very easily, if ever. Be careful how you describe your partner and his or her actions. You know that what he or she is doing is not *really* them. Don't portray your partner as the perpetrator of wrongdoing. That description belongs only to ROCD, which is safe to say is a separate machine entirely.

Counselors aren't just for sick people

Many people make counseling a part of their lives for just having someone to talk to. We all have thoughts or feelings that we don't necessarily want to discuss with our friends and family.

There are different types of mental health practitioners. The term "counselor" usually refers to a psychologist, however these titles may also apply to licensed social workers.

The difference between a psychologist and a social worker is the level of education and field of study. You would see a psychologist if your counseling needs included mental illness. You would speak to a social worker if you just needed help dealing with "life" issues.

It may help to speak to a counselor if you feel like you need a little back-up in dealing with your ROCD relationship. This is useful, not only in having a safe outlet for your feelings, but also in catching and avoiding unhealthy behaviors in yourself that can lead to bigger problems.

Not only will a counselor be less likely to be opinionated or biased, he or she will be especially good at just letting you vent. A common practice for these professionals is to help you identify and understand your feelings on your

own. It is true that most of us already know the answers to our problems, but due to busy lives, we don't get a chance to slow down and think about them. This is what counselors are especially good for.

Additionally, due to confidentiality laws, you don't have to worry about having your personal feelings and thoughts broadcast to all of your family and friends.

Chapter Five:

Worst-Case Scenario

It is common with Relationship Obsessive-Compulsive Disorder for the sufferer to become convinced that he or she must end the relationship.

Partners in ROCD often don't know what to do when the worst happens.

This chapter covers what one can do when the sufferer is considering or has ended the relationship.

Many partners involved in ROCD relationships have to endure not only the constant doubts, but the results of those doubts. This includes the sufferer's belief that he or she must end the relationship, due to the idea that he or she does not love the partner.

This can be emotionally devastating for the partner, as he or she loves the sufferer, and is against ending the relationship. Emotions typical in breakups are intensified because of the irrational nature of the sufferer's behavior.

Preventative Measures

An important thing for one to know is how to avoid helping his or her partner's ROCD grow to an intensity that can lead to breakup. This involves knowledge of what should be avoided in reaction to post-spike behaviors. Knowing what *not* to do is equal to, if not more important than knowing what *to* do during one of these cycles.

Though some of this has been noted in previous chapters, due to relevancy, it is necessary to re-cover some information about how partners can strengthen the effects of ROCD.

Don't Freak Out

The best that one can do when experiencing the effects of his or her partner's ROCD is to try to remain calm. Emotional responses to your partner's behaviors or confessions may work to add weight to your partner's doubts. The sufferer is experiencing his or her doubts due to anxiety. Added anxiety contributed by the partner's emotional reac-

tion may increase the sufferer's feelings of desperation, and the inclination to get out of the relationship.

However difficult, don't let your partner's ROCD dictate your feelings. By staying calm and controlling your reactions, you will have a better chance of making it through the cycle with your relationship still intact.

Leave it in the past

If you have already experienced one or more breakups due to ROCD, staying calm may be more difficult. Every time your partner has broken up with you as a result of ROCD, you may have developed more intolerance and distrust. The number of times this has occurred will impact the strength of these feelings.

In this case, you will have to work harder to keep calm. You may be "tired" of this, but bear in mind that your partner does not see the pattern as you do. A person with ROCD may recognize that he or she has done this before, but does not logically consider that in previous cases the process was uncalled for. All he or she knows is how they feel now.

Don't carry emotions from previous experiences into a current cycle. Let go of what cannot change or be taken back, and only deal with the present issue. Don't let that which you can't control upset you. This will help you emotionally, by preventing responses which would make things worse.

From your experience, you are likely aware that your partner is not trying to hurt or upset you, and that he or she

has little control of ROCD. Keep this in mind, and it may help reduce your frustration.

Bleeding Hearts

During an ROCD cycle, displays showing a lack of confidence can add weight to your partner's idea that you are not the ideal mate. Trying to get your partner to feel sorry for you does not help your case. Efforts to gain pity should be avoided.

It is natural for a person to ask “why”, or to be hurt by criticism. Hearing that your partner doesn't love you is painful. Unfortunately, natural empathy or motivation to stop hurting the partner is not usually present in an ROCD cycle. That would suggest love, which is what ROCD is working against.

There is usually only one consideration the sufferer may give to the partner. This is that staying in the relationship will hurt the partner. Although this may make the sufferer believe he or she is being considerate, this is only an excuse created by ROCD for the purpose of relieving uncertainty, and has little to do with sympathy.

The sufferer doesn't intend to and can't help hurting the partner. Intent is never part of the equation. Neither is the ability to recognize the unfair or irrational nature of thoughts. The sufferer can't stop at will, thus a partner's requests for that are pointless. They will only work to worsen the circumstance by showing signs of weakness, which are naturally unattractive.

A common mistake in this circumstance is a partner's intensified pleads to the sufferer to "have a conscience". Each failed attempt at reasoning with the sufferer results in the partner stepping up attempted persuasion. This works against them, because, in most cases, the harder they try, the worse it gets.

God's Gift

Overemphasized displays suggesting that a partner will be "just fine" without the sufferer, or doesn't care, can give the sufferer more reasons to believe the relationship is wrong. The sufferer may "rationalize" the partner's lack of attachment signifies there is not enough love in the relationship.

This can also work to inspire defensive reactions for emotional protection. Remember that your partner's ROCD may might be influenced by pain from previous relationships, in which he or she was rejected. Your partner may see your lack of attachment as an indicator that you will leave *them*.

This can stimulate a response or "reasoning" that leads to the sufferer leaving you *first*. Unfortunately, it is rarely true that the partner intends to leave the sufferer. The sufferer developed the obsession, and subsequent defenses due only to an exaggerated idea in his or her own mind.

Balancing Act

A partner would need to find a balance between minimal and exaggerated confidence. This would mean to care enough, but not too much. This can be tricky, especially when emotions are involved.

The emphasis is on reactions characterized in chapter 4, where it was advised to state your truth and back away. Don't deny your feelings, or hide them. Claim your disapproval and opposition to what is happening, while making it clear that you love your partner and want to stay in the relationship. Be careful not to put too much pressure on your partner, as it will likely result in strengthening doubt, and impelling a breakup.

I think maybe it's time

If your partner reaches a level where he or she tells you that it "may be" time to break up, you have a few choices to help block the event from happening. That he or she stated that it "might" be necessary is an indication that a decision has not been reached... Yet.

Your response should not be defensive, but rather a calm recognition of your partner's feelings. Acknowledge your partner's concern, but affirm your belief your relationship is fine, and things will work out. He or she isn't convinced that the relationship is over yet. Use this as an opportunity to promote the relationship. The point is to provide something to tip the scales enough to allow the possibility of working things out to remain a consideration.

There are several ways you may be able to do this. One way is to try to help your partner remember happy moments between the two of you. Without the pressure of convincing, and referring only to *recent* events, talk happily about experiences. Smiling and laughing while recalling events may be helpful by inspiring those emotions in your partner. Keep this specific to moments in which you and your partner were together.

Another helpful thing may be to do something together. This should be something that your partner enjoys. Activities such as miniature golf, or similar interactive and fun occupations may help your partner regain some positive feelings about the relationship. Your attitude should be positive and playful. Smiling and laughing are naturally contagious. Try to show your partner that he or she can be happy in your relationship.

Though this is often helpful, it may not be effective in helping your partner work their way out of a cycle. You should prepare for the possibility that these efforts may have little or no results. In such case, you have the option of simply asking your partner to give things time.

It is common for a spike to occur during times of stress. The causes of this stress can be unrelated to your relationship, such as financial worries. It is common for people to unknowingly allow stress to enter or exaggerate circumstances in other areas of life, such as intimate relationships.

This is true for ROCD, however the sufferer doesn't recognize that his or her feelings about the relationship are caused or intensified by unrelated circumstances. Additionally, given the obsessional tendencies already present, magnification of perceived problems is significant.

Should this be the case, a partner has the option of helping the sufferer identify the stressful elements in other areas of life. Then he or she may be successful in suggesting the possibility that those are affecting the partner's feelings. If the sufferer is open to this idea, he or she may resolve to give the relationship more time before ending it. If you can help your partner maintain this perspective throughout the

cycle, you may avoid a breakup. Since ROCD is cyclic, it is only a matter of time until your partner returns to "normal".

This issue of giving things time is important. ROCD's cyclic nature all but guarantees that if a partnership can hold together long enough, the intensity of the threat will begin to subside. Partners should encourage "time" as much as possible, while avoiding putting pressure on the sufferer. Although the sufferer may doubt that time will help, he or she will likely oblige.

Uncertainty cannot exist when there is nothing present to argue with the idea. Certainty is to be *without* doubt. That doubt is the primary symptom of ROCD, and is cyclic, strongly supports the suggestion that somewhere inside, the sufferer loves the partner, and does not truly want to leave.

It is when obsessions have reached a point of intensity that the chance of avoiding a breakup may be small. Contradictions become overwhelmed by doubt, possibly because of the partner's excessive pushing and emotional reactivity. When ROCD has reached this stage, a partner would need to prepare themselves for a break up.

It's Over

According to the sufferer, no love is present, and there is no point in carrying on with the relationship. "I've decided." This is the sufferer giving in under the pressure of *uncertainty*.

The sufferer concludes that since he or she cannot relieve

the confusion by substantiating the relationship, it must mean that love is not present. The sufferer does not recognizing that it is his or her own irrational obsessing that is the cause of the uncertainty. They develop the conclusion that the uncertainty, and the inability to settle it, can only mean they don't love the parter and must end the relationship.

Partners have little to no chance of stopping the breakup. Attempts to reason with or influence the sufferer to reconsider or wait are useless. Once the sufferer has reached this point, all a partner can do is accept that it's done. Now they can only wait until the cycle has concluded, in hopes that a reunion can be had.

Reconciliations are not uncommon. Regret often closes a cycle, depending on harm done. In the event that a breakup occurred, the sufferer will often reconcile with the partner. Either the partner waits until the sufferer calms down and makes the effort to get back together, or the sufferer is the one to approach the partner.

How long a partner waits until the option to reconcile is open is never certain. Cycles can be over quickly, or can last for weeks. It is hard to know what a partner can do to influence the conclusion to the cycle.

Residential Conflicts

Separation is more complicated when partners are living together. There are more issues involved, such as who stays and who goes, division of property, and of course, where the person who must leave is going to go.

Fortunately, it is these complications that may actually help in waiting out a cycle. Since these circumstances often take time to work out, a partner can use this to his or her advantage.

One way is to communicate these complications to the sufferer, and suggest waiting things out before commencing such burdensome tasks. It may be appropriate to offer to go and stay with friends or family to give the sufferer some space. This helps in providing more immediate relief, thus enabling the potential for ending a cycle.

This can require a few days or more, and means to stay away. Pack enough so you will not need to return to the home for a while. If you do need to visit the home, try to do it when the sufferer is not there. After a while, you may be able to enter discussion about working things out. There is the possibility that, before long, the sufferer will request for you to come back.

Stay patient and respectful, as this is for giving your partner time to calm down. Don't do anything to create more anxiety.

It may help to suggest marriage or couples counseling. The process of separating when living together is complicated, and this suggestion may be accepted by the sufferer. Although you are aware that the problem is not in the relationship, this can help to buy time. Also, a counselor may help in getting your partner to accept that these events occur due to circumstances of his or her own creation. If your partner is unaware of his or her OCD behaviors, this would be significantly helpful.

However the residential issues of the separation tran-

spire, make sure you take care of yourself. Don't give in so much that you put yourself out unnecessarily. There is a difference between what is reasonable and what is ridiculous. Don't allow your partner to submit you to unfair circumstances. Unless you did something *really* wrong, you don't deserve to be punished or treated unfairly.

To speak or not to speak

The phrase "Absence makes the heart grow fonder" is fitting when describing the reasons behind a "no contact" approach. By resisting the urge to communicate with or otherwise contact the sufferer, you may be able to speed up the process of ending a cycle, and inspire a reconciliation.

A sufferer may hold on to his or her conviction for a while, but eventually will begin to miss the partner. Assuming the relationship was good, and there were no significant problems, it is only natural that the suffer would begin to regret his or her actions.

Without the partner there to influence doubts, the sufferer would likely begin to calm down, and start thinking logically again. Eventually the sufferer is able to realize that his or her feelings of love do exist, the relationship is of value, and he or she wants it back.

Sometimes, despite these feelings, the sufferer may not make any effort to restore the partnership. This can be for a variety of reasons. One may be that due to the incessant nature of his or her doubts during a spike, he or she cannot trust feelings of love. In retrospect, the sufferer recognizes that he or she has gone through inner turmoil over doubts

about the relationship's value. It is not so easy, then, to be certain about opposite feelings of love and the desire to be with the partner. Unfortunately, due to this inability to feel sure about his or her true feelings, the sufferer may decide to just give up on the relationship.

Other possible reasons for the sufferer not to make efforts to reconcile are pride, embarrassment, shame, guilt and other feelings. The sufferer may feel that due to his or her actions, he or she does not deserve the partner. Another possibility is the assumption that the partner is upset and does not want to be with the sufferer any longer.

This presents the basis for the question of when and how to communicate with the sufferer. If the parter wants to get back together, he or she will need to confirm that this is possible. If the sufferer is not communicating, it will be up to the partner to engage conversation.

The partner should not do this right away. Give things time to calm down, and wait before trying to reestablish communication. This usually means a few days, but sometimes longer durations are needed.

It is important that this does not turn into “badgering” or otherwise overwhelm the sufferer. Respect for personal space is necessary. Remember that you need to avoid pushing the sufferer into further doubt.

The ideal way of handling this is to be open to the sufferer and help him or her feel like they can talk to you. Be sure to let him or her know that you still love them, and are not holding grudges against them. If the sufferer doesn't want to talk about it, don't insist.

Slowly begin offering to get together for little things, such coffee or a movie. Check in on them every once in a while (not constantly), to see how they are doing. Remain friendly, and avoid making the sufferer feel guilty. You can say that you miss them, but don't overdo it. Try to keep an appearance of gentle strength.

Though this will likely test your patience, it is important not to communicate your impatience to the sufferer. This will put them on the defensive, and will do nothing to help your circumstances.

It is worth noting that in the event of not reuniting, ending contact with your partner is the best way to begin moving on. Continued interaction with the partner may be counterproductive, as maintaining contact symbolizes the presence of a "relationship" in your perception, thus giving you something to hold onto. Letting go is key to moving on. You should do this if you have good reason to believe there is little to no likelihood of saving the relationship. Hope is *not* evidence of a possibility. One should be careful that they are not waiting on the basis of hope alone.

Reunited

In the case that you and the sufferer are able to restore your partnership, you should begin working toward getting the ROCD under control. It is not healthy for either person

to continue these cycles. Intervention is necessary. Don't assume that because the two of you are back together the problem is solved. It is only a matter of time until you are faced, again, with your partner's ROCD, and its consequences.

Chapter Six:

Getting your partner to get help

Many OCD sufferers don't know that they have the disorder. If general OCD symptoms are minor, and ROCD is the prevalent version, it may be harder for one to recognize his or her problem. This means that getting diagnosed may take longer than would more severe, debilitating levels of the disorder.

The first step to getting help is to recognize its presence. It is difficult for sufferers of ROCD to do this on their own. Partners can be of significant help in this process.

This chapter will provide a partner with ways that he or she can help the sufferer recognize that he or she has a problem, and get help.

NOTE: In chapters 4 and 5, there suggestions that may contradict those in this chapter. To clarify possible confusion, this chapter specifically relates to the active process of persuading the suffer to get help. This should only be done when a partner is ready to implement the practices suggested here. If the partner is not fully prepared for this, he or she should maintain the behaviors suggested in previous chapters.

One of the hardest parts of being in an ROCD relationship is the inability to rationalize with the sufferer. The sufferer's behavior is abnormal, but partners are helpless to get the sufferer to see this. This especially applies when OCD has not been diagnosed.

It is a common mistake for partners to forget about ROCD when it is dormant. It is when ROCD is not active that one has the best opportunity to talk to the sufferer about his or her tendencies. A person with OCD usually knows that he or she has illogical or irrational tendencies, although this knowledge appears to be missing during an obsessional cycle. If your partner is aware of the "problems" he or she has occasionally, approaching them may be easier when ROCD is dormant.

Unfortunately, in some cases, despite knowledge of the problem, the sufferer will resist addressing it. Most people don't want to accept their mental illness, because they think it will label them as "crazy".

The first step to convincing your loved one to get help is to prove that he or she needs it. Much like presenting a case to court, you will need to gather indisputable evidence of your partner's problem. There also needs to be something to motivate them to get help, not just the illness alone. Many people will live with a problem until something occurs in their lives that forces them to get help. This may require an ultimatum or similar motivation from you.

Exhibit A

ROCD is often described by partners of sufferers as "forgetful". The sufferer forgets happy moments and loving declarations to the partner, and only remembers flaws and incompatibilities. When a partner tries to argue, saying the sufferer's loveless declarations don't make sense, and could not be true, the sufferer doesn't acknowledge the truth behind these claims.

As long as the rebuttals are unsubstantiated by evidence, the sufferer is unlikely to consider the potential of the partner's claims. He or she may, instead, become angry at the partner's argument and shut them out. This is why it is important to come up with ways to prove the sufferer wrong when they start claiming there is not enough love in the relationship.

This will require the partner to gather as much evidence as he or she can, that he or she can't make up. The following is a list of some items that may help a partner prove the sufferer is "missing" some things. These should be a <u>recent</u> as possible.

Letters, emails, texts, or voice messages from the sufferer professing love

Video footage of the sufferer in "loving" circumstances

Pictures together in which both are apparently happy

Gifts from the sufferer to the partner

Although it may sound intrusive, a partner may find audio recordings useful in this effort. One can carry a pocket voice recorder and use it during moments when the sufferer is expressing happiness in the relationship, and feelings of love toward the partner. This may or may not create conflict when the partner tries to use recordings as evidence, as the sufferer may view this is a secretive, invasive and dishonest measure.

However, it may be necessary in getting the sufferer to realize the contradictions. The partner could express that he or she felt this was needed to help when the sufferer starts obsessing about the relationship. If the sufferer gets angry, it should not be with the partner for defending the relationship. It was not a betrayal, but a calculated measure to keep the sufferer from destroying a good relationship. If the sufferer is "allowed" to devaluate the partner in his or her own mind, the partner has a right to defense.

The following is an example of how a partner worked to get solid evidence of a sufferer's claims of affection during dormancy of ROCD.

"My girlfriend and I were driving to a town a couple of hours away. While I drove, she was in control of the radio. She put on a song, and told me that it made her think about how

much she loved me. Jokingly, I said, "No way. This song is way too deep. It must make you think about the other guy you love." Though recognizing that I was joking, she responded with argument. "I only love you, and I will always only love you!" she said to me. I said, "Promise?" She affirmed.

I took a piece of paper and a pen out of the center console, and handed them to her. She looked at me, obviously confused. I said, "Write it down so I can carry it with me." Smiling, she took the paper and pen and wrote "I love you, always and forever." She wrote the title of the song, the date, and signed it with a heart next to her name. I placed the note in the console, and told her, "Ha! Now you can't ever take it back!" She said she wouldn't dream of it, and kissed my cheek. I eventually used the note when the OCD kicked in and she started doubting her love for me."

Write it down

Keeping a daily journal is another option for supporting contradictions to the sufferer's beliefs. It may not be possible to have texts, voice messages, or to sneak an audio recorder everywhere you go. Keeping a dated journal can help you accurately recall certain events.

A sufferer may argue that the partner's memory is inaccurate when recalling events that supposedly contradict the sufferer's beliefs that he or she does not love the partner. His or her version of the circumstance may not line up with that which you recall. The best defense for this is to document the circumstance as accurately and immediately as possible. If your circumstance allows, let the sufferer see that you are keeping a journal. It is not necessary to tell them why you are keeping it.

A journal is also helpful for the partner in documenting cycles. Each ROCD case and circumstance is unique. Keeping a journal of your partners reactions to certain things may help you learn about his or her ROCD. While reviewing past entries, you may be able to discover patterns for what causes spikes, what helps reduce intensity levels, and what makes things worse.

Additionally, this can be helpful in showing the sufferer how frequent these cycles are, and the similarities of each case. You can show them what happens before they start, how long they last, what is said, and how they typically end. This serves to help the sufferer realize that their feelings are intermittent, supporting the suggestion of a problem.

Presenting Your Case

When the sufferer experiences a spike and enters an obsessional cycle, you should have your "defense exhibits" ready.

Be careful not to come on too strong. Try to be as gentle as you can when you engage your partner into this debate. Avoid tones that would motivate further defensive reactions from the sufferer. He or she is already experiencing confusion created by his or her own mind. You will be adding to the confusion, making it worse. This is necessary, but should be done delicately.

It is important that you keep a loving, understanding nature. If you come across as accusatory or combative, you will not likely achieve your goal. You should try to keep a

gentle, firm position, while displaying a loving, nonjudgmental attitude. If you appear judgmental, your partner will not likely open up to hearing your side. You are telling them that something is *wrong* with them. They are more likely to consider this possibility if they feel like they can trust you not to judge them or think they are crazy.

It may help to try to relate with your partner. Although this can be a like a double-edged sword, identifying your own "eccentricities" may motivate acceptance. This would be of your own judgment call, as if not done correctly or inappropriately timed, it may work to produce additional doubts about you.

If you exercise this option, it's best to do it when your partner is not at a peak of a spike, and is calm. The purpose of this method is to help them see that flaws and "weirdness" is not uncommon. You could start off by identifying a friend or loved one's abnormal habit, yet also noting how this person is good, and nice to be around.

If you both know someone close who has gotten therapy for a problem, it may help to talk about them. The process serves to get your partner to see that it is not abnormal or weird that he or she has a mental illness. Breaking down the barriers of stereotyping and showing him or her that "It's Okay" may be paramount in getting your partner to get help.

If your partner becomes too overwhelmed or upset, you may need to back off. Although what you are doing is necessary, it is not necessary to put your partner through excessive stress. Additionally, you want to avoid pushing them into depression or panic. It may not be easy for your part-

ner to absorb the fact that they have a problem, and are creating the doubts themselves. This can be a shock to some, as learning that theirs minds are "playing tricks" on them can be a scary experience.

It's possible your partner may experience guilt or shame when he or she realizes what is happening. The guilt may come from his or her recognition of what ROCD is doing to the relationship and to you. At a more personal level, your partner may become ashamed, as he or she may feel disgust that they are doing these "crazy" things.

This may result in sadness and depression. He or she may start apologizing for hurting you, and criticizing themselves. These are natural feelings, and can work to motivate the sufferer to get help. They may also work to other degrees. Partners need to watch the sufferer and act appropriately if he or she witnesses behavior that can be troubling, such as suicidal thoughts or statements.

Conveying that you understand, are not judging your partner, and are supporting them is critical. His or her pride may not allow them to accept your help, and if this is the case, you should focus on sending a message of unwavering love - that you aren't going anywhere.

Pack a Lunch

Partners should not expect immediate results from these efforts. The process of identifying, accepting, and getting help can be a long one. Also remember that just because your partner accepts that he or she has a problem, it does not mean that it is fixed. OCD is not a matter of choice. It is

an illness that requires treatment to control.

The steps of this often go as follows:

1. Your partner refuses to believe that anything is wrong
2. Your partner recognizes the *possibility*, but is not fully convinced.
3. Your partner recognizes the problem, but believes he or she can control it.
4. Your partner "slips", but will try harder to control it.
5. Your partner think *maybe* he or she should get help.
6. Your partner finally goes for a consultation with a therapist.

The process may not follow this order exactly, and may not include all of the steps. Sometimes the sufferer can go backward instead of forward. Therefore, it is important for a partner to keep in mind that this may not be quick or easy. How long it will take to get your partner in for diagnosis depends on him or her, and how you go about helping them recognize the problem.

One of the hardest parts for a sufferer may be crossing the threshold between knowing he or she has a problem, and doing something about it. A sufferer may avoid the next step either out of procrastination, or simply not wanting to talk to a therapist out of pride or fear. Many sufferers will continue with the belief that he or she can control the ROCD on their own.

As long as the partner allows this to go on and doesn't push for therapy, the sufferer may never take the step of meeting with a therapist. This is a mistake, and partners should try to avoid enabling the sufferer to continue like this.

Each time the spikes occur, the weaker your relationship may become. Also, the longer your partner waits to get help, the longer he or she will have the illness. If your goal is to save the relationship, then your goal is getting your partner to see a professional, and get started on therapy as soon as possible.

Don't Forget

It's important not to let the topic of the sufferer's ROCD fall to the "back burner" in daily life. Partners should not avoid the subject, but rather bring it up regularly. Perhaps every other day you can ask the sufferer if he or she has considered certain things, such as whether they would rather talk to a male or female therapist.

The sufferer may get irritated and express frustration with how frequent the subject is brought up. Your response to that could be something like, "I'm sorry that it frustrates you, but until you do something about it, I will have to keep asking you. I want you to get help." Avoid arguments or offensive tones. Your approach should be loving and respectful.

You're not alone

ROCD is treatable, and can be significantly controlled by therapy. Unfortunately, knowing that "simply" by getting help, a sufferer can beat the problem is usually not enough to motivate a person to get treatment.

Perhaps the knowledge that the sufferer is not alone, and that many people suffer from OCD and ROCD may help.

The U.S. population, as of July of 2007, was over 300,000,000 people. Studies have reported that approximately 2% to 3% of the population has OCD. That's at least 5,999,999 *other* people who have OCD. OCD is the 4th most common mental illness. Considering how many types mental illnesses are out there, that's a big deal.

Modestly assuming only 1% of OCD sufferers have ROCD, that would be 60,000 people in the U.S. alone. That is equal to the population of Palo Alto, California, home of Stanford University. It is reasonable to assume that ROCD is not uncommon, and the sufferer is not alone in his or her illness.

There are Internet message forums that are dedicated to OCD. Some of these forums also have topics specific to ROCD, in which sufferers talk about their problem, and support others with it. Perhaps getting the sufferer to review some of these forums could help them to feel less "alone".

Let's make a deal

Perhaps a negotiation would help get your partner into a consultation. It's common for partners in normal relationships to work out a trade when one wants the other to do

something. Obviously, with ROCD, the exchange would work best if equal in value.

For example, if you are an addicted smoker, and your partner is not, you could make a promise that if your partner gets help, you would quit smoking. This is fitting, because you are both working with a mental challenge. Both require behavioral training, and can involve medication. You need to keep your promises to each other. Additionally, each of you should not only want to do these things for each other, or for the sake of relationship, but for yourselves.

There is much room for creativity when it comes to negotiating an agreement. It is not a good idea to set up an environment of "punishment" into this equation. The sufferer should not view therapy as a bad thing or a burden, and so agreements or partners' expectations should be adjusted to avoid influencing this stigma. Rewards fair better than punishment.

Cruel to be Kind

If your partner has either procrastinated too long, or worse, refused to get help, your choices become quite limited. It is reasonable to assume that your efforts and requests for your partner to get help are ignored, regardless of excuses you may hear. At this point, you may need to be more firm about the issue, of course without being disrespectful or mean.

There are two things to consider when you have reached this point. The first is that you cannot go on living with

ROCD uncontrolled. It is unhealthy, and it hurts you. Second is that it is clearly going to take serious measures to get your partner to choose to get help.

The only choice you have is to remove yourself from the situation. It is best to do this when your partner is *not* spiking. One way to go about this is to give your partner a week to schedule an appointment with a therapist. If your partner does not schedule an appointment, you will leave until he or she has had the first appointment. You may not be taken seriously, so you must follow through.

If you live with your partner, make plans with family or friends to go and stay with them if your partner ignores your ultimatum. Prepare appropriately, as it is unknown how long you'll be staying away. It is important that you do not give in and go home before your partner has sought help.

If your partner calls and tries to get you to come back, simply ask if he or she has gotten help yet. If their answer is no, so, too, should yours be. By showing that you mean business, you are insisting that you be taken seriously. If you give in, you will have a harder time being taken seriously in the future. Your partner will remember your threat, and how empty it was, since you didn't follow through.

If your partner schedules an appointment, make sure he or she *goes*. The ultimatum exercise may be necessary to ensure that your partner actually attends the appointment.

If your limit should be reached during an active ROCD spike, the same applies. Instead of hanging around and dealing with the effects of the spike, you may want to leave, and refuse to come back until your partner has sought help.

You can tell him or her that this has happened too often, that you have tried to be nice about it, but now you must put your foot down. Do not enable the ROCD by going back if your partner is doing nothing about a problem he or she *knows* about.

Your partner may not seek help no matter what you do. In this case, you must ask yourself if it is good for you to stay in the relationship. To keep going back is to keep living in a cycle. This is neither good for you or your partner. It is your choice.

Chapter Seven:

Choosing a Therapist

Choosing the right therapist can mean all the difference in successfully treating ROCD. Considerations should include compatibility, expertise, and financial issues.

This chapter covers topics commonly associated with the process of finding a therapist who can affectively treat OCD and ROCD.

Each person and circumstance is unique. This should be considered when thinking about the use of information contained in this chapter. Though it covers issues common in the subject of choosing therapists, it may not be complete to every person's circumstance.

It's up to YOU

For therapy to be effective, the sufferer will need to be open to *receiving* it. If a sufferer cannot trust therapeutic procedure, it will not matter who he or she gets help from. It will likely be ineffective regardless of how "good" the therapist is.

It's a common mistake for patients to assume that they know better than the therapist when it comes to therapeutic plans. These people will often say things like "I'm not doing that!", or "I don't think that's necessary."

The sufferer will need to clear out any thoughts or beliefs that will prevent him or her from truly benefiting from therapy. He or she will need to accept that the therapist is a trained professional. This means that he or she has likely spent as many as 10 years studying and treating mental illness.

Sufferers should not be resistant to the help they are seeking. If they knew how to solve their problem, naturally there wouldn't *be* a problem.

Trust is important. While trust is typically developed through good relationships between therapists and patients, the patient will need to be open to trusting the therapist first. After that, the potential of the relationship depends on communication, respect, rapport and compatibility.

Compatibility

There are things to consider first before beginning the search for a therapist. One is whether the sufferer would

feel more comfortable with a male or female. Some people are more comfortable opening up to others of the same sex, while others find women more receptive. This should be resolved before making any inquiries to professional services.

Religious compatibility may be a concern. During therapy, it is common for patients to discuss private thoughts and feelings. Religion is relative to a person's feelings, behaviors, and personal limits. It may be a good idea to seek a therapist who shares the same beliefs, as his or her treatment practices may be more accommodating to a sufferer's religious background. This can be an important element to the sufferer's inclination to trust the therapist.

For example, if a sufferer is agnostic or atheist, he or she may not be comfortable with a therapist who may refer to "God" or intelligent creation in the process of therapy. This may create problems for the sufferer by affecting his or her ability to respect or take the therapist seriously.

It may help to write down a list of personal preferences one might want to consider before beginning the search for a therapist. These may include geographic location, availability on Saturdays, preferences about medication, and other possible considerations. It would be unrealistic to assume that one could find a therapist that meets all of these preferences. After making the list, decide what issues are important, and what can be overlooked. This gives one a place to start when contacting potential therapists.

It's Complicated

It is a common mistake to assume that one can go to any

mental health professional and receive proper treatment for their problem. This is not true, and the result of this belief is often misdiagnosis, failed treatment, and other circumstances that waste a person's time and money. Finding the right type of therapist is probably the most important factor in getting healthy.

First, one should know the differences between various types of mental health practitioners. When dealing with OCD, these are primarily in the fields of psychiatry and psychology.

Psychiatry

Psychiatry is a medical field in which professionals focus on the biological "nuts and bolts" of human processes. A psychiatrist generally deals with physical impairment, such as neurological dysfunction.

Treatment methods common in psychiatry include some form of physical alteration, such as medications to manipulate neurological changes. Psychiatry is a field based on the theory that mental illness is a *physical* issue, and cannot improve without changing physiological elements.

If one should choose to see a psychiatrist, he or she would be working with someone who does not usually associate environmental circumstances with causes of OCD. He or she can expect to be prescribed medication. Additionally, the diagnosis may include blood tests, CT scans, and other investigative medical procedures.

Some psychiatrists do extend their treatment practices into the areas of psychology, which focuses on behavioral

and environmental circumstances.

Psychiatrists have the "M.D."title, which stands for Medical Doctor. M.D. is associated with medical practice, and not research and theory. PhD., however, indicates a practitioner who may also teach in the psychiatry field, and works with research and theory. For diagnosis and treatment, one would usually consult someone with the M.D. title, and not Ph. D., with some exceptions.

Psychology

Psychology is a field that is associated with treating mental illness through behavioral "training". Sometimes referred to as "alternative medicine", psychology does not typically involve clinical issues, such as physiological dysfunction. It focuses on habit and environmental conditioning, and the theory that patients can be "untrained" of their mental illness.

Practitioners of psychology are called psychologists, and the degree associated with this is "Psy. D". Psy. D means Doctor of Psychology. A psychologist can diagnose and treat patients, but is not licensed to prescribe medications in most states. The exception to this rule is New Mexico, in which psychologists were given license to prescribe medication in 2002.

There is much debate about whether this was correct. The point of opposition is that psychologists have insufficient education in physiological fields, and do not understand pharmaceutical directive or affect. Psychologists are not medical doctors, in terms of diagnosing and treating

physical conditions.

Some believe that should psychologists everywhere be given license to prescribe medication, the field should require intensive medical training. This means the difference between psychiatrist and psychologist would be less defined.

New Mexico passed legislation to give psychologists license to prescribe medication mainly for providing medicinal treatment to rural or low-income residents. This was because the majority of psychiatrists practice in Santa Fe, and practitioners in other areas were scarce.

The directive of psychology is to work with brain function and response to environmental stimulation. Simply put, in mental illness, the brain was trained to respond to the environment incorrectly. Psychological treatment involves exercises to retrain the brain to respond correctly to environmental stimulation, without physical manipulation.

Other licensed professionals, such as clinical social workers, professional counselors, psychiatric nurses, and some psychiatrists may work with psychotherapy. Additionally, psychologists may refer patients to psychiatrists for the purpose of incorporating medication with behavioral therapy.

The nature of each field may be an important subject of consideration when deciding who to consult for therapy. If a sufferer is inclined to associate his or her OCD to a physical condition, he or she may prefer a psychiatrist. If, however, he or she feels that causes involve environmental circumstance, such as childhood upbringing or emotional trauma, a psychologist may be the best option.

Additionally, one might consider whether he or she is comfortable with medication. If not, it may be wise to avoid psychiatrists, as medication is typically the route for treatment in this field.

Specializing in OCD

A person who has a vision problem would not consult a foot doctor for treatment. This same logic applies to mental health. Practitioners typically specialize in specific areas of mental illness. An OCD sufferer should not seek treatment from a professional who specializes primarily in children with ADHD.

Finding a doctor whose practice is specific to OCD is a necessity. Obsessive-Compulsive Disorder is an illness that has specific elements involved in diagnosis and treatment. Consulting a professional who does not have significant knowledge of OCD will likely result in misdiagnosis and improper treatment.

Many professionals claim that they are trained in and can treat OCD. Unfortunately, some of these don't actually *specialize* in the illness, but include it in a general group of illnesses with which they are *familiar*. They may have some knowledge, and a general understanding of OCD, however do not qualify as experts.

This is an especially important consideration for ROCD. ROCD is not a typical form of OCD. Therefore, the sufferer should try to find a practitioner who has significant experience with and understanding of obsessional behavior. If the practitioner either doesn't recognize or understand the be-

haviors associated with ROCD, he or she would not be reliable for effective treatment.

If one has difficulty finding someone with knowledge of or experience with ROCD, he or she might try to find a professional who is "open" to the existence of the disorder. A good candidate would have a good understanding of how OCD works. He or she would be interested in studying the nature of relationship-substantiation. If the practitioner validates this form of obsession without being too inclined to "funnel" it into *general* OCD, there is hope of effective treatment.

This "funneling" is a common complaint by sufferers of many illnesses, not just OCD. It is a common cause for misdiagnosis, and is a failure to perform the profession of treating mental illness properly. Causes for this may be any of the following:

- Overwhelming caseload resulting in the doctor not having enough time to devote to specific cases
- Inadequate or out-of-date training
- Laziness, or other form of unprofessionalism

It is a common mistake for people to assume that because someone has a medical degree, he or she is always "right". If this were true, there would not be personal injury and malpractice claims in health care, which was approximately 35,000 a year between 1995 and 2000. That means that about 95 claims are filed every day.

The following is a list of statistics about the number of deaths a year that are caused by medical negligence in the

United States:

- **12,000** deaths per year from unnecessary surgery
- **7,000** deaths per year from medication errors in hospitals
- **20,000** deaths per year from other errors in hospitals
- **80,000** deaths per year from infections in hospitals
- **106,000** deaths per year from non-error, adverse effects of medication

Up to 30% of patients receive improper or inadvisable treatment per year.

Considering those statistics, it is safe to say that not all who practice medicine, or work in medical fields, are always correct.

That is why it is important to find an expert in OCD, who has verifiable experience with the disorder. He or she should have a track record for effective diagnosis and treatment, and is current with research studies and findings.

When first talking to a potential therapist, ask about his or her training and experience with OCD. Find out if OCD is a primary expertise, or if it is only one of a group of specialties. Look for someone who deals with OCD regularly.

Ask is if he or she keeps up with current research, and continued education about OCD. New information about potential causes, symptoms, and treatments is discovered regularly. Sometimes new information contradicts previous theories, and even disqualifies previous diagnosis and treatment standards. Studies of OCD are ongoing, as researchers try to understand this illness and prove potential

causes.

If a therapist is not current with new discoveries, he or she may subject you to outdated and wrong diagnosis and treatment procedures.

Ask if they have ever heard of ROCD, or relationship substantiation obsessions. If not, find out if he or she feels that it is something they can treat. The answers you receive should provide you with enough information to decide whether he or she is right for you.

A prime indicator that a doctor may provide less than satisfactory results is his or her claim that ROCD doesn't exist. Also, stating one's relationship substantiation obsessions are not indicative of a serious mental health problem is a warning sign. One may be wise to look elsewhere if a doctor says that he or she doesn't see a problem, or the problem is not debilitating enough to cause alarm. The sufferer and his or her partner should know better than to accept these suggestions.

There are good, qualified therapists available that can provide excellent help to those suffering from ROCD. One should not settle for a therapist that falls short of inspiring total confidence in his or her professional capacity. This includes conveying an accurate understanding of what the sufferer is experiencing in ROCD.

If such understanding is clear, there's a good chance the therapist will be able to treat the problem. If, however, the sufferer does not feel the problem is understood, it's a signal that he or she may want to seek help elsewhere.

This is also the case if a therapist claims to know what

the problem is, but describes symptoms or circumstances that do not accurately describe the sufferer's experience. This is how one can recognize potential misdiagnosis, and a therapist who will not properly treat ROCD.

Opinion vs. Fact

In Chapter 3 of this book, it was conveyed that potential causes of OCD are theoretical, and no one knows for certain how it develops. It is important to keep this in mind when considering a mental health professional for treatment.

Some professionals may claim that they *know* what causes OCD, or will disqualify potential causes because of his or her belief. This "limited" view subjects a person to be treated only within the scope of the practitioner's opinion.

For example, if a mental health professional insists that OCD is only caused by neurological dysfunction, the patient is all but guaranteed to receive medication. The problem with this is that studies show that OCD is often treated successfully with behavioral therapy, without medication.

Such inflexibility limits the patient's options to chemical treatments, which often have side effects, and are not always necessary or effective.

A doctor who claims to *know* what causes OCD is not basing this knowledge on scientific fact, but on personal opinion. This claim is impossible to substantiate, and may be indicative of potential malpractice. Doctors who practice on the basis of opinion which is contradicted by science are more likely to be subjects of malpractice claims due to er-

rors in diagnosis and treatment.

After diagnosis and receiving a proposed treatment plan, one may want to consider getting second or third opinions. This can help one to feel confident that he or she is receiving the right kind of care. Receiving conflicting diagnosis or treatment suggestions is an indication that *someone* is wrong.

Scheduling Conflicts

One should try to find a doctor whose schedule can work with the theirs. Compromise is to be expected, but not to a level disruptive to one's life routine.

If the proposed treatment schedule would interfere too much with one's job, parenting schedule, or other need, he or she may want to move on in the search for a therapist. If this isn't considered, hardship in these areas may occur.

For example, if you're divorced and have a visitation or parenting schedule, and your therapy schedule interferes, you may lose precious time with your children. This may result in resentment of your therapy schedule, and may lead to dropping out of therapy.

Therapy should not be unreasonably inconvenient. One should try to find a therapist whose schedule can be worked harmoniously into existing routines. Therapy will not work if the patient cannot attend.

Exclusive relationships

It is not uncommon for doctors to work with other doctors, and may have associates take their place in sessions

with their patients.

It is important to some sufferers that they see only one person about their problem. This is usually because it takes time to get comfortable discussing personal matters and develop trust. Switching doctors may have a negative impact on progress that could be had for that session. Also, the regular doctor is familiar with the patient and his or her personal circumstance. Regardless of notes left, or briefing of a patient's circumstance, the stand-in doctor may not have necessary understanding of a patient's complex issues.

If one feels that having an exclusive doctor tend to his or her treatment is important, this is something to ask about. Look for a therapist who can confirm that he or she is the only doctor the sufferer will be working with.

Fees and Insurance

Therapists usually set their own fees, which typically range from $90 to $200 an hour. Some therapists arrange their fees on a sliding scale, adjusting them to accommodate various income levels.

Insurance can be of great help in covering the costs of therapy. One may get insurance through his or her employer. It is not uncommon for people to increase their working hours or other means to qualify for employer-provided insurance.

If the employer doesn't provide insurance benefits, it may be appropriate to seek other employment that would provide insurance before starting therapy. The costs avoided may justify the change in employment.

One can get insurance by applying directly to insurance companies as an individual or family. Like auto insurance, health insurance premiums would be paid on a monthly or other incremental basis. This process includes picking a plan that has ideal coverages, including mental health. Premiums would be based on the plan chosen, and the applicant's risk factors, such as smoking or preexisting medical conditions.

If one has insurance, he or she may want to consult an insurance representative before beginning the search for a therapist. Depending on policy limits, mental health may not be covered. If it is covered, it may only apply to therapists within the insurance company's network of providers. It is typical for insurance companies to require significantly increased co-pays for services from doctors not included in their network. Some insurance policies will not cover these at all.

If there is no insurance, the alternatives are to pay out-of-pocket, or get help from other resources.

Many cities have programs available at low or no cost. Locating these services can be difficult, but usually worth the effort. It may include several phone calls, being referred to different places repeatedly, and other patience challenges.

2-1-1

The 2-1-1 initiative was created to help Americans get free, easy access to local services information, such as finan-

cial assistance, Medicaid or Medicare, transportation, and physical or mental health services. This 24-hour hot line is available to most Americans through a landline phone, by simply dialing 2-1-1.

If one is uninsured, and is trying to locate low or no-cost mental health services, he or she should tell that to the representative who answers the call. The representative would then locate resources for this issue. The caller is then provided phone numbers that may be of help. This is usually only the first step, and the caller should expect to make a few more calls before getting the to the right service or department.

2-1-1 is free, and is sponsored by United Way and other human services organizations. It is available in most areas in the U.S.

Other ways one can look for assistance is by visiting their local government's website or looking in the local phone book.

Local community colleges or universities may be of use if one is looking for discounted services. Some schools that teach psychology or psychiatry have clinics available to the public. These services are often made available to give students “hands on” experience in their education.

Students provide therapeutic services to other students and to the public either free or for low fees. The students are supervised and coached by their professors (PhD), to help them provide proper care. Medication may be unavailable. If one is interested in this option, he or she could simply contact the administrative office and ask if this service is available.

Obviously free or discounted services significantly limit one's options when it comes to choosing a therapist. This may be discouraging. However, one could consider that therapies received by local government services or by colleges are more likely to be inspired by true interest of *helping*, rather than financial rewards. Additionally, one should not allow financial issues to stop him or her from getting help. The phrase "something is better than nothing" certainly applies here.

Money Trap

D. writes:

"When I finally got my boyfriend to agree to go to a consultation, I was ecstatic. He didn't have the time or the resources to find a therapist, so I was happy to help him with that. We lived states apart, so I had to use the Internet to find a doctor in his city. I was able to find one that claimed to specialized in OCD, and called to inquire of his services.

I ended up leaving a message, explaining the purpose of my call, and that I was not local. I requested a call back, which I received the following day. When the doctor called, I explained the circumstances and told him that my boyfriend was willing to come in for diagnosis. I informed him that my boyfriend didn't have health insurance, and I would be paying for the session.

After establishing how I would make payment, I was told to have my boyfriend call him to talk and schedule an appointment. He did the same day, and everything was all set after I prepaid for the hour-long consultation.

After the appointment, my boyfriend called to tell me how it went. His report was upsetting. Apparently I paid $175.00 for my boyfriend to go and "hang out" with this doctor. The doctor spoke little about the problem that was the purpose of the visit. He casually said that there "may be" some OCD tendencies. My boyfriend said that they spent the majority of the hour talking about trivial things, like the weather.

My boyfriend and I share the opinion that this was a total waste of money, and the doctor basically ripped me off. The doctor knew my boyfriend didn't have insurance, and wouldn't be able to afford continued treatment with him. So he didn't even bother with a diagnosis, but simply accepted my money to "bs" with my boyfriend."

The experience is not uncommon, and is an example of some doctors' forgetfulness of their promise "*To keep the good of the patient as the highest priority* ". It is unfortunate, yet true that some doctors' financial priorities supersede those of providing a good, honest service.

Predicting a doctor's ethical practice is nearly impossible, but there are ways to limit the potential of being "taken".

Being clear about expectations is important. When first calling to set up a consultation, one should be sure to state what it is he or she is looking for, such as a diagnosis. Find out if this is something that can be expected or what to expect from the first session.

Therapy is a business, and the patient is a customer. A paying customer has the right to know and choose what it is that he or she is buying.

First call says it all... almost.

When one makes the first call to a therapist, it should not be to schedule an appointment, but to speak with the doctor about potential services. One should not be satisfied with speaking only to a receptionist for information. If the doctor won't speak personally, or requires a consultation appointment (and inclusive fee) to discuss his or her services, move on.

One should be looking for a therapist willing to speak with the sufferer personally, and discuss services before making an appointment. This may include leaving a message requesting a returned call.

When speaking with a therapist, ask questions, but also pay attention to the person's attitude and communication. It is important that patients get along with therapists, and can *like* them. If the therapist has all the right answers, but his or her attitude is unappealing, he or she may not be an ideal choice.

Try to find a professional who knows what he or she is doing when diagnosing and treating OCD. The professional should meet compatibility preferences, and have a personality that appeals to the sufferer.

Chapter Eight:

Professional Treatment

Treating ROCD will include therapies used to treat OCD. ROCD will likely be diagnosed in the spectrum of OCD, due to the obsessional nature of relationship substantiation.

This chapter covers common methods used to treat OCD. These include prescription medication and behavioral therapy.

This chapter is for informational purposes, and is not intended as therapeutic advice. Please consult a licensed qualified professional before trying to "self-treat", using methods described in this chapter.

When ROCD is diagnosed, it will likely be as a subform of OCD. Treatment plans will include those typical of OCD.

Treatment plans may vary, depending on the therapist one chooses to use. If a psychiatrist is used, treatment will likely include prescription medication. No medication has been proven to associate with specific obsessions, but some are found to work better than others in treating certain OCD traits.

With ROCD, the scope of medication will likely involve antidepressants. The exceptions would be if there were other disorders involved, or OCD is severe. In that case, medication used for treatment may include those not commonly used with OCD, such as benzodiazepines (antianxiety) and antipsychotics.

Medications do not cure OCD, but lessen the effects of the disorder by chemical manipulation. It's believed and supported by research that long-term control of OCD is most often achieved when medication is used in combination with behavioral therapy. If not, symptoms will likely reappear once one stops taking medication.

Temporary Relief

Benzodiazepines, also known as tranquilizers, are medications used to temporarily reduce affects of anxiety or panic. These are typically addictive, and often used on an "as needed" basis, though sometimes regularly for up to two weeks. These are not commonly prescribed for OCD unless panic or anxiety symptoms are present. These do not treat OCD, but provide temporary relief of panic symp-

toms.

One medication under this scope that may have benefits associated with OCD is Rivotril (clonazepam). It is believed to have an impact on serotonin balance, and may be preferred over other benzodiazepines. Other tranquilizing medications commonly prescribed are:

Ativan (lorazepam)

Xanax (alprazolam)

Valium (diazepam)

Serax (oxazepam)

Restoril (temazepam)

Antipsychotics

Antipsychotics may also be prescribed in combination with antidepressants, especially in cases that include panic disorder. Researchers say that roughly half of OCD sufferers taking antidepressants alone show improvement. For unresponsive cases, or obsessional behaviors difficult to treat, doctors may prescribe an antipsychotic medication in addition to antidepressants. The medications typically used for OCD are:

Haldol (haloperidol)

Orap (pimozide)

Risperdal (risperidone)

Antipsychotics block dopamine receptors. Excess dopamine release is linked to psychosis, and may be present in some cases of OCD.

Antidepressants

Antidepressants are the most common medications prescribed in cases of OCD. There are different types of antidepressants, based on the primary function of the medication. Antidepressants typically used in cases of Obsessive-Compulsive Disorder are SSRIs, SNRIs, TCAs, MAOIs.

SSRI Medication

SSRI stands for Selective Serotonin Reuptake Inhibitor. The word "selective" is used because these medications work with specific neurotransmitter receptors, whereas other antidepressants are not selective and work with several. It works by giving serotonin more time to be absorbed by the receiving components (receptors) in the brain.

Some believe that OCD may be caused by underabsorption of this chemical, due to the function of "reuptake". Reuptake is like a backward pump that sucks up the excess serotonin after receptors are given time to absorb the chemical. This is like a recycling process, in which neurotransmitters can be reused later.

Perhaps, in OCD, the reuptake happens too quickly, and not enough serotonin is getting to receptors. It's theorized that by inhibiting this backward pump, more serotonin can be absorbed by the receptors. This is what SSRIs do.

Common SSRI medications prescribed for OCD are as follows:

Luvox (Fluvoxamine)
Prozac (Fluoxetine)
Zoloft (Sertraline)

Paxil (Paroxetine)
Lexapro (Escitalopram)
Celexa (Citalopram)

Each of these has the same basic function, however may have slight differences in reaction, such as the time it takes to start working, whether it works at all, or whether it makes problems worse. Also, some of these have more side effects than others. As each person is unique, and so may be his or her response to medication. What works well for one person may not work for another. Another difference is withdrawal symptoms one can experience from stopping medication.

SSRIs work as antidepressants, and are mostly used to help those with depression symptoms. However, these have also been found to help OCD. The dosage prescribed for OCD patients is usually significantly higher than that for depression.

Possible side effects of SSRIs include:

Nausea
Dizziness
Disorientation
Irritability
Trouble Sleeping
Vivid Dreams
Restlessness
Weight changes
Constipation
Diarrhea
Heartburn
Dry mouth

Sexual dysfunction

SSRIs should not be taken in combination with some other types of drugs. These include SNRIs, MAOIs, and tricyclic antidepressants.

SNRI Medication

SNRI stands for Serotonin-Norepinephrine Reuptake Inhibitor. These work similar to SSRIs by inhibiting the reuptake of serotonin, however they also inhibit the reuptake of the noreprinephrine neurotransmitter. Norepinephrine is associated with stress signals linked to dopamine, and works as a "Fight or Flight" stimulator. SNRI medications commonly used for treating OCD are:

Effexor (venlafaxine)
Serzone (nefazadone)

Side affects of SNRIs are similar to those of SSRIs.

TCA Medication

TCA stands for Tricyclic Antidepressant. These are sometimes referred to as SRIs (Serotonin Reuptake Inhibitor). Where SSRIs are selective, TCA medications have a broader affect on neurotransmitters. This also means a broader scope of side effects.

There is one TCA medication primarily used for OCD, which is Anafranil (Clomipramine). It affects both serotonin and dopamine. Side effects are common with those of SSRIs, and may include memory problems.

MAOI Medication

MAOI stands for Monoamine Oxidase Inhibitor. These are usually the next step in treating OCD if SSRIs or TCAs are ineffective. These are used less commonly, as side effects and food or medication interaction are more problematic. When taking an MAOI, one needs to be very careful about taking any other medications, including over-the-counter drugs, as severe or fatal reactions may occur.

This is especially true for taking SSRIs, SNRIs, or tricyclic antidepressants. In addition, foods high in tyramine should be avoided. These include alcohol, soda, orange juice, caffeine, some dairy products, some meat products, avocados, tomatoes, bananas, peanut butter, vanilla, chocolate, and others. Usually, doctors will only prescribe MAOIs to patients who can be trusted to adhere to these limitations.

Like other antidepressants, MAOIs work with serotonin, but also the neurotransmitters dopamine and norepinephrine. Where other antidepressants block the reuptake function, MAOIs inhibit the "garbage" function. There is an enzyme in the brain that works to destroy "used" neurotransmitters. MAOIs inhibit this enzyme to allow the presence of more neurotransmitters.

This is why serotonin reuptake inhibitors and MAOIs cannot be used together. If the used transmitters aren't disposed, and the excess chemical reuptake function is inhibited, there would be too much serotonin. This could lead to serotonin poisoning. Serotonin poisoning can lead to fevers up to 106°(F), severe rapid heart rate, and other life-threatening conditions.

Common MAOIs prescribed for OCD are:

Nardil (phenelzine)

Parnate (tranylcipramine)

Common side effects of MAOIs include those of SSRIs, SNRIs, and TCAs. Additional side effects may include:

Drowsiness
Weakness
Fatigue
Loss of appetite
Fainting when standing up
Hypertension
Slow speech or thought
Anemia
Headache
Anxiety
Tremors
Mania
Urinary frequency
Rash
Flushing
Increased perspiration
Blurred vision
Muscle twitching

No two medications are the same in chemical composition. Though they may have the same or similar results, how one is affected by introducing these chemicals into the body is considered. Some doctors prefer certain medications over others.

It is common to start treatment on one medication, only to later switch to something else. This may be due to unfavorable side effects, OCD being unresponsive, or other

causes. Also, it is common for a patient to start out on lower dosages, and gradually increase to a level that produces results.

It is important for suffers to take these medications exactly as prescribed. Missing doses should not result in "doubling up" the next time. One should not stop medication without instructions from a doctor, as many of these medications have withdrawal effects.

Alcohol use is discouraged. Alcohol could have a negative effect on the medication, and disturb chemical balances. Alcohol affects the release of neurotransmitters, as well as causing a depressant affect. Combinations of alcohol and antidepressants commonly impair one's inhibition and judgment, significantly more than alcohol alone. This can be serious in some cases.

For example, a patient taking Prozac and consuming alcohol may result in the lack of natural restraint and judgment so significant that he or she removes his or her clothes in a public place.

The amount of alcohol does not have to be significant. The body's reaction to combining alcohol and antidepressants or other medications vary by person, and may be severe. This same warning applies to recreational drug use.

Watch what you're eating

It may be helpful to research medications your partner is prescribed to better understand its purpose. Certain things should be considered, such as how long it has been in circulation, what it does, possible side effects, and statistics of results in OCD patients. It may be better to avoid new drugs (under 5 years in circulation), due to the lack of information

regarding long-term affects. New medications may not have had enough time in circulation to allow severe problems to be drawn to attention.

As an example, a recently-introduced medication was approved by the FDA, and promoted as an aid for smoking cessation. Commercials and other media promoted this new drug that could help "cure" smoking addiction. This is reported to have worked for many. However, what wasn't widely publicized were the major depressive side effects many reported shortly after starting this medication. Some patients even committed suicide. While there are no official studies linking the medication with the suicides, the number of occurrences and reports of severe depression may speak for itself. News companies have been attracted to this issue, and have even reported on the "coincidences".

New medications are introduced to the medical field so often, it may make one to wonder how doctors keep up with them. The pharmaceutical industry is one of the highest profiting businesses in the United States.

Many medications have been recalled by the FDA (Food and Drug Administration) because of side effects or adverse reactions. This usually occurs after there have been enough reports of death or severe problems related to these medications.

Commercials are regularly aired on television, advertising class action suits against pharmaceutical companies. These suits include wrongful death, development of cancer and other illnesses, and other damages. Many have lost loved ones due to medication problems.

The pharmaceutical industry pays out hundreds of millions of dollars a year in damages from lawsuits.

It may be appropriate to do your own research on the medication, instead of relying solely on the doctor's opinion.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy is the process of "untraining" a person from incorrect behavioral response to environmental stimulation. This therapy is usually provided by psychologists, and can be exclusive, or in cooperation with medication. While medication only works with the symptoms, CBT works with the problem. Medication may be excluded in CBT, because CBT involves purposeful exposure to obsessions. One cannot face a problem to fix it if symptoms are not present.

Exposure and Response Prevention

Exposure and Response Prevention (ERP) is one of two typical parts of Cognitive Behavioral Therapy. Though this may be practiced exclusively, OCD therapy usually includes ERP with Cognitive Therapy.

ERP is the most common behavioral treatment for OCD. It involves controlled exposure to situations or circumstances that cause an OCD sufferer to spike. In the controlled environment of a therapy session, these spike-inspiring circumstances may be real or purposefully imagined. In imagined situations, the sufferer is told to think of a circumstance that commonly results in obsession. He or she would try to "feel" the results as though they were exposed to the real-life circumstance.

The point of exposure is to place the sufferer in "troubling" circumstances, to purposefully face the obsessional

behavior. It is believed that through repeated exposure, the suffer can “get used” to the ideas that create anxiety. The sufferer is not allowed to resist the thoughts, but rather welcome them head-on. This usually starts with minor, less anxiety-provoking circumstances, and progresses intense spike-inducing situations.

In ROCD, this therapy may include sessions in which the partner is present. Although this may be helpful for the sufferer, partners may not want to subject themselves to criticism. Whether this practice is considered appropriate varies among therapists.

In this case, the sufferer is told to look at a feature of the partner that influences anxious feelings.

For example, if the sufferer thinks the partner's feet are unattractive, and this normally causes him or her to react with fears of lovelessness, he or she would be exposed to the partner's feet. Instead of resisting the fears that arise from looking at them, the sufferer engages them purposefully.

If done repeatedly, eventually the sufferer should feel less anxiety about the unattractive feet. This should result in reduced anxiety, thus reduced substantiating behaviors.

The “Response Prevention” side of this treatment focuses on the results of thoughts associated with spike-inducing circumstances. This is the reaction of feeling like one must substantiate his or her feelings toward the partner so that he or she can feel confident about the relationship. The substantiation is the response behavior in ROCD. This is similar to how an OCD sufferer needs to wash his or her hands after shaking another's.

For example, a male sufferer is in a social situation with

the partner. A person jokingly makes a statement that the partner is "weird". The sufferer takes this seriously and thinks about whether his partner really *is* weird. "Well, if he thinks she's weird, maybe she is," he thinks. This is a thought the precedes a spike.

The response is the obsession that follows, in which the sufferer will start obsessing over possible clues that he is with a "weird" woman. Her behavior comes under his microscope as he obsesses about whether she truly is weird. This unfailingly leads to the conclusion that she *is* weird, and he doesn't love her. After all, he can't love someone if he thinks she's weird.

Response prevention is the process of disallowing the sufferer to begin the behavior of substantiating the relationship. He or she is intentionally exposed to spike themes, but cannot engage the behavior that is done to bring relief. This can be especially difficult when the behavior is secret, or in the sufferer's mind. He or she is not allowed to begin the analyzing the relationship. This usually goes on anywhere from hours to days, and works to give the sufferer practice in not letting these thoughts develop into obsessional behaviors. Over time, restraint from acting out the response becomes easier until the sufferer has little to no difficulty.

This therapy often includes homework. The sufferer may be given assignments to complete in between sessions.

A common assignment is to practice "Self-Directed ERP". An example of these assignments is keeping a stack of index cards, on which are written statements about the partner.

"She laughs loudly"

"I find other men attractive"

"She doesn't have my sense of humor"
"He doesn't like to garden like I do"
"She's taller than I prefer"
"He's not as tall as I prefer"
"My friend says he's hard to get along with"
"My mom thinks she can't cook"
"He has a big mole on his arm"
"She has a lot wrinkles around her eyes"

The sufferer would look at these cards several times a day, to produce exposure to spike-themes. Then he or she would practice response prevention, in which he or she tries to control the thought from leading to substantiation behaviors, such as examining at the partner to locate feelings that prove "love".

Cognitive Therapy

Cognitive Therapy (CT) is often included with ERP. It is the process of confronting the beliefs that create anxiety. Thoughts that occur in normal relationships, such as "his breath is terrible right now", develop into obsessions in ROCD. The sufferer believes that this thought indicates a flaw, which suggests that he or she is not attracted to or doesn't love the partner.

This belief process is what is challenged in CT. The therapist will have the sufferer describe the justifications of his or her beliefs, but also describe contradictions to the belief.

An assignment commonly given to sufferers is keeping a journal. The sufferer is to write down spike and obsessional circumstances in chronological format. An example of this is as follows:

1. What was the situation?
She and I were in the grocery store.

2. What was the intrusive thought?
Her hair is really dry.

3. Describe what the intrusive thought means:
I find her dry hair unattractive.
If I am not attracted to her hair, I must not be attracted to her enough.
What if I am with the wrong person?

4. Resulting Behavior or Ritual:
Look at other parts of her body that may be unattractive, for clues of significant unattraction.
Watch her personality for flaws indicating incompatibility.
Look at other women to see if I am more attracted to others.
Look at other couples and compare our relationship to theirs for clues that I'm in a bad relationship.
Look for love "feelings" when I look at her
Mentally list what I find attractive and how she doesn't fit the list.

After the sufferer learns to identify thoughts and resulting behaviors, the beliefs that result in the behaviors are examined. The sufferer would make a list of ways to support these beliefs. Then he would make a list that contradicts these beliefs.

Supportive Information

Love isn't real unless there is total attraction.

If she doesn't have all of the physical features I want, she is not right for me.

If I really loved my partner, I would not find other women attractive.

True love is finding the perfect woman.

A relationship in which one does not always feel "in love" with their partner is doomed to fail.

Contradicting Information

I have flaws, too.

No one can be perfect.

My dad gets annoyed with my mom sometimes, but I know he loves and is happy with her. They've been together for over 30 years.

My best friend's girlfriend has crooked teeth, and he is considering proposing to her.

My friend and his wife have an ongoing joke about his crush on a supermodel. They are one of the happiest couples I know.

My brother's fiancé is quite average-looking, not what people would normally describe as beautiful. He doesn't ever seem to stop talking about how great she is.

Using the contradicting information, the sufferer is coached to identify distortions in the beliefs that necessitate the behaviors. For example, if it were true that one must always feel "in love" with his partner for love to be present,

his parents would not have made it 30 years in their relationship. This identifies a distortion in his beliefs.

After identifying the distorted beliefs, the suffer is then coached to develop *new* responses to intruding thoughts. The results would produce less anxiety. The sufferer should be able to have normal thoughts without developing the "need" to do something about it.

For instance, when the sufferer identifies his partner's dry hair, he sees it, but is not compelled to respond with substantiating. Yes, she has dry hair. Yes, he doesn't find it particularly attractive. No, it does not mean that he doesn't love her, or that he is insufficiently attracted to her.

Once the sufferer develops consistency in his or her ability to assert new responses based on adjusted beliefs, he or she has reached a successful turning point. He or she has begun to control the OCD.

The process of adjusting beliefs to discredit the need for certain responses is called Cognitive Restructuring. The restructuring is considered to be effective for controlling OCD in the long-term, because it causes the suffer to change the thinking that supports OCD behaviors. Changing the thinking is part of changing the response.

The process of CBT typically takes 14 to 16 weeks to produce significant results. Studies report that 75% or more OCD cases treated with CBT are successful, and produce long-term results beyond 2 to 3 years after therapy.

Group Therapy

Group therapy is commonly suggested for the purpose of providing an empathetic environment. The group would consist of other people who have the disorder, and discuss

personal experiences with it.

The experiences may be positive or negative, and emotions shared range from hopelessness to triumph. The benefit for the sufferer is to provide support from those who know what he or she is going through. The knowledge that one is not alone in his or her experience can provide much relief in the pressure of defeating an illness.

Group therapy is also an avenue for discussing what has helped an individual in their efforts to control OCD, and what has hindered them. This information is helpful, because it is generated from actual experiences, rather than a generalization or simplification that may be received from a therapist. A therapist, though knowledgeable in OCD, cannot fully "understand" what OCD feels like, unless the therapist has personal experience with the disorder. Though this should not discount the therapist's credibility in treatment procedure, group therapy can provide a sufferer with the added support of empathy.

Group therapy also helps to remove the sufferer from self-absorption, by creating his or her own empathetic feelings toward others in similar circumstances. This empathy, or ability to relate, works to separate the sufferer from his or her own problems, and see OCD from another perspective. When the sufferer hears of someone else's struggle, he or she will have an easier time recognizing the true nature of a problem, and, perhaps, a solution.

It is a common belief that we already know the solutions to our problems, we just have a hard time seeing them because we are so immersed in the effects. Desperation, anger, sadness, and other feelings prevent us from being able to step back and observe problems from a detached perspec-

tive. Our process of logic is controlled by our emotional attachment to the subject.

The empathetic nature involved in observing others with similar problems allows for this detached perspective. Logical solutions can be more readily apparent. Sufferers can then consider how these can be applied to themselves.

Because ROCD is not commonly exposed or addressed in OCD-focused professional communities, finding group therapy that is specific to ROCD may be difficult. These may not even exist locally. This is an unfortunate reality, but it doesn't mean the sufferer cannot benefit from group therapy for OCD in general. ROCD is a form of OCD, and consists of obsessional behavior. Individual therapy requires addressing the specific nature of the problem, but group therapy does not.

The therapies described in this chapter are most common, however a therapist may have additional, or alternative methods of treating OCD. One therapist may advise against the use of medication, while another incorporates it into his or her therapeutic practice.

A sufferer should not expect quick results. The process of training one's mind to becoming obsessional did not likely happen overnight, but over a course of time. The process of retraining the mind to react correctly to thoughts will take time, as well. It is like starting with a skinny, weak body, and training it to become that of a career body builder. It takes time and hard work.

OCD cannot be cured, but only controlled. A sufferer will always have OCD, just as an alcoholic is always an alcoholic. The sufferer will likely face challenges of OCD for the rest of his or her life. However, with treatment, these chal-

lenges become less significant as one builds strength against them.

Surgery

In some cases, psychiatrists may resort to surgical procedure to relieve severe OCD. This is the cutting of the cingulum, which is the "belt" linking brain areas, such as the basal ganglia and the limbic system.

If other methods of treatment are unsuccessful, surgery may be the alternative.

The cutting of the cingulum results in the ceasing of message transmissions from one part of the brain to another. This procedure is call "Cingulotomy". If the cingulum is dysfunctional, it may cause failed communication, or "mixed signals". Medication may not be affective in treating this condition, and relief may be provided if the areas affected are "deactivated".

This surgery is a rare alternative, and typically applies to severe cases of otherwise untreatable OCD. This doesn't typically impact other brain functions, and has been found to help up to 30% of patients.

Chapter Nine:

Alternative Treatments

This chapter covers alternatives some have found to be helpful in treating OCD. These include supplements, alternative medicine, diet, exercise, and THC.

This content is for informational purposes only, and is not to be considered as professional advice.

Please consult a licensed professional before attempting use of any alternative treatment practices described in this chapter.

Missing Ingredients

Some reports have found that OCD may relate to glandular dysfunction. It is not uncommon for one to be diagnosed with a mental illness, when the true problem was found to be glandular deficiencies.

Hormones, such as thyroid and adrenaline, may have an association with developing anxiety disorders, depression, psychosis, and OCD. It may be possible to reduce symptoms by treating deficiencies in glandular production.

Hypothyroidism

Hypothyroidism affects roughly 3% of the population. It is the underproduction of the thyroid hormone. Thyroid hormone helps regulate organ function, burn energy, stabilize reactions to other hormones, and more.

Common causes of hypothyroidism are iodine deficiency, missing thyroid gland, or dysfunction of the pituitary or hypothalamus glands. Another possible cause may be the use of lithium-based antidepressants. Some women in postpartum unknowingly have hypothyroidism, and confuse it with postpartum depression.

Those with hypothyroidism may have been diagnosed with clinical depression, bipolar disorder, ADHD, and severe PMS (Premenstrual Syndrome).

Early symptoms of hypothyroidism may be difficult to detect, but are commonly characterized by the following:

Fatigue
Susceptibility to cold
Dry skin
Dry, thin or brittle hair and nails
Low heart rate

Weight gain
Paleness
Poor muscle tone
Muscle or joint pain
Depression

If hypothyroidism continues undetected, later physical symptoms can include the following:
Voice changes
Hair Loss
Abnormal menses or cycle
Migraine headaches
Anemia

Mood or mental problems may also develop if hypothyroidism goes untreated. These can be mild or severe, and include the following:
Memory problems
Focus problems
Mood instability
Anxiety
Panic attacks
Dementia
Delirium
Hallucinations
Psychosis
Delusional belief

Obsessive-Compulsive Disorder has a high rate of appearance in those diagnosed with hypothyroidism. A simple blood test at a family clinic can identify this problem. If

diagnosed, doctors usually prescribe synthetic thyroid hormone, and advise dietary changes.

Alternatives to prescription drugs for hypothyroidism are raw thyroid gland concentrate, and other supplements used to support thyroid function. These supplements are commonly found at natural food and drugstores. Many who suffer from hypothyroidism begin feeling better within a week of starting a synthetic or raw gland concentrate of thyroid, and experience better mood. However, there is speculation that taking thyroid-replacers inhibits the body from making its own hormone. Though relief from hormone replacement may be more immediate, it may be best to consider methods of promoting thyroid recovery.

Adrenal Fatigue

Adrenal fatigue is a condition most commonly referred to by alternative medicine practitioners. There are disputes among medical professionals about whether adrenal fatigue exists.

It is arguable that if hypothyroidism can develop as a medical condition, so too, may adrenal fatigue, as it is defined as underproduction of adrenaline.

Doctors will rarely test for this, as many believe it doesn't exist. It is up to one's opinion or prerogative to investigate the possible existence of this problem. Some have claimed to have experienced improvement in mood, energy, overall health, and OCD symptoms by addressing adrenal concerns.

Adrenal fatigue has been associated with OCD, as well as hypothyroidism. In fact, adrenal fatigue is suggested as a possible *cause* of hypothyroidism, and may be worth inves-

tigating if one is diagnosed with this thyroid dysfunction.

Adrenal glands produce the hormone adrenaline, also known as epinephrine. Adrenaline is considered to be the body's first line of defense in stressful situations. It is associated with feelings of excitement, whether stressful or happy. The term “adrenaline rush” describes a feeling of raised heart rate, heightened stress and awareness, and other symptoms of sudden adrenaline release. It is a hormone used in identifying danger and defensive response.

Adrenaline is responsible for the ability to respond to stress. Adrenal fatigue may be caused by traumatic events or prolonged exposure to stressful or traumatic environments. The theory is that adrenaline is overproduced so regularly that the gland function becomes impaired, due to being overworked. Adrenal fatigue may also be related to regular excessive caffeine or stimulant consumption.

If the adrenal glands fail to produce adrenaline, it may cause an inability to cope with stress, resulting in anxiety, panic, and other emotional reactions. In normal circumstances of stress a person should be able to cope without experiencing anxiety. A person with adrenal fatigue has regular exaggerated emotional reactions, such as panic attacks and anxiety. Anxiety is a primary feature of OCD.

Symptoms of adrenal fatigue include the following:

Fatigue

Added effort to complete normal activities

Dependence on stimulants to function normally

Inability to cope with normal stressors

Dizziness or fainting during stress

Latent heart racing or pounding (not during stress)

Frequent episodes of anxiety or panic

If one believes that adrenal fatigue may be present in his or her circumstance, over-the-counter supplements are available. These are raw adrenal gland concentrates, and adrenal support supplements. Additionally, dietary adjustments may be necessary, such as caffeine reduction.

Practitioners who believe in the existence of adrenal fatigue commonly advise stress reduction. The gland would need time to recuperate, and exposure to stress would inhibit this. Lifestyle adjustments may be necessary in avoiding stressful situations. Additionally, it is believed that adrenal fatigue does not happen quickly, but over time. So, too, will recovery. However, although not a cure, the use of other-the-counter adrenal gland concentrate may produce faster results.

OTC: Serotonin, Dopamine, and Norepinephrine

NOTE: Supplements that stimulate, inhibit, or otherwise affect neurotransmitters should not be taken with prescription antidepressants or other medications without first consulting a doctor. Severe or fatal results may occur.

There are over-the-counter supplements available that affect the production and absorption of neurotransmitters associated with OCD. Many have reported that these have been helpful for controlling mood and anxiety, which may have affects on onsets of OCD spikes. If one considers the use of over-the-counter supplements, he or she should do research for specifics regarding intended use, dosage, and

side effects.

5-HTP

5-HTP is short for 5-Hydroxytryptophan, and is a precursor to serotonin production. This chemical is believed to stimulate production of serotonin, leading to increased serotonin release.

OCD may be caused by underabsorption of serotonin, and 5-HTP may be helpful in improving symptoms of this problem. 5-HTP has been found to help other problems, such as depression and chronic headaches.

One may consider using vitamin B6 when taking 5-HTP, as this helps the body digest the chemical. Some manufacturers combine B6 with 5-HTP.

SAM

SAM, or S-Adenosyl methionine, is a chemical known to have a part in the formation of serotonin and dopamine. By inducing production of these neurotransmitters, SAM may be helpful in circumstances of serotonin and dopamine absorption deficiency, which may cause OCD.

It is typically found under the name "SAM-e". One may want to include vitamin B6 when supplementing SAM, unless already included by the manufacturer.

L-Tyrosine

L-Tyrosine is the starting point for production of the neurotransmitters dopamine and norepinephrine. The supplement helps by increasing the levels of L-Tyrosine in the brain to produce more of these neurotransmitters. L-tyrosine is commonly known to increase energy, improve cogni-

tive and physical response, as well as affects on stress reduction.

L-Tryptophan

L-tryptophan works as a precursor to serotonin and melatonin (sleep), and works to help your body naturally create 5-HTP. It is an essential amino acid found in foods, such as turkey, and is not created naturally in the body.

L-Dopa

L-Dopa is an agent associated with creating dopamine in the brain, which works to increase production of the neurotransmitter. L-Dopa may be a helpful remedy for deficiencies in dopamine absorption, which are associated with OCD.

GABA

GABA (Gamma-aminobutyric acid) is a chemical that acts to inhibit synapses (absorption of neurotransmitters) so the receptors do not absorb too much hormone. Where other supplements work to help produce more neurotransmitters or inhibit reuptake, GABA works as a regulator. Some believe that anxiety disorders, such as OCD, may be caused by deficiency of this inhibitory chemical. Without it, hormones that act as stimulators for defensive reaction may be over-absorbed, causing increased stress and anxiety.

The supplement may reduce anxiety, induce calm feelings, and other benefits that are helpful to mood or anxiety disorders.

From the Earth

Some herbal extracts and plants may be effective alternatives to prescribed medication in treating OCD. Plants such as St. John's Wort, Melissa Officinalis (Lemon Balm), Lavender, Passiflora, Marijuana, and others are claimed to have beneficial affects. One should do research on plant uses and possible side effects before starting a treatment program including these.

St. John's Wort

St. John's Worth (hypericum perforatum), though grown commercially, is considered a noxious weed in many countries. It has been known to be so invasive to cause problems with land crops. If it gets into pastures, St. John's Wort can cause photosensitivity (sensitivity to light), problems with nervous system and breeding, and even death in livestock.

However, in humans, St. John's Wort has developed a reputation as an antidepressant. It is available over-the-counter in most countries, excluding Ireland, in which one must have a prescription.

The antidepressant use of this herb is effective on mild to moderate cases, with significantly less side effects than conventional antidepressants. However, studies indicate that St. John's Wort is not effective on cases of major depression.

Though nothing has been proven, scientists believe that St. John's Wort operates as a serotonin reuptake inhibitor, like tricyclic antidepressants. Side effects of St. John's Wort, vary, and may be more intense for some than others. Some believe it can cause anemia, and should be taken with an iron supplement. Other side effects include:

Tiredness

Dizziness

Confusion
Fertility problems
Photosensitivity
Mania in bi-polar sufferers

St. John's Wort works as an antidepressant and affects serotonin, therefore it should not be taken with other medications. Serotonin poisoning has occurred to some who have used this herb in combination with other antidepressants. Serotonin poisoning makes one very sick, and can be fatal.

St. John's Wort is commonly used with an additional herb supplement, called Passiflora, or Passion Flower.

Passiflora

Passiflora usually grows as a vine, but in some species appears as a shrub. It is known commercially for its fruit, which is called Passion Fruit. For medicinal use, the leaf and root are the areas of interest.

Passiflora has the same chemical used in MAOIs. It is typically used for insomnia, hysteria, and as a pain killer. It is also used for antianxiety, and an OCD remedy. It can be ingested either as solid herb (capsules), as a tea, or smoked. Possible side effects include allergic reaction and drowsiness.

Melissa Officinalis

Melissa officinalis, commonly referred to as Melissa or Lemon Balm, is an herb that is related to the mint family. It is commonly used as a calming agent, and sedative. Some studies have shown that Melissa may have stress reducing

effects. It is usually ingested as an extract, but leaves can be ground for use in capsules, or dried for tea.

Lavender

Lavender is commonly known for its calming aromatic features, but is also reported to have sedative and calming effects when ingested as a tea or in a capsule. A tea is usually made by steeping dried flower heads. Capsules typically contain the dried flower and ground seeds. Lavender may have some side effects, such as allergic reaction and photosensitivity.

Kava Kava

Kava Kava (piper methysticum) is a plant whose roots are used for their tranquilizing effects without the sacrifice of mental clarity. It is popular as a stress reducer and calming agent. It is said to promote muscle relaxation, "happy" feelings, and even mild euphoria. It is sold as teas, dried bulk, and in capsules. Kava Kava is popular for these effects, but there are some precautions to consider before consumption. In addition to allergic reaction, liver damage has been associated with regular consumption of Kava Kava. Consumers should do research before using this plant as a remedy.

Valerian Root

Valerian (Valeriana officinalis) root is commonly used as an antianxiety treatment, muscle relaxant, and sedative. It is sometimes used as a transitional supplement when patients are discontinuing antianxiety medication.

Side effects include stomachaches, headaches, and vivid

dreams or nightmares. Prolonged use may have more adverse affects. Research should be done before using this supplement, as side effects can be significant to some.

Marijuana

Studies show that marijuana (cannabis) is effective in treating compulsive disorders such as Tourette's and tics. Both Tourette's and tic disorders are linked to OCD. However, science has not been able to prove cannabis as an effective treatment for obsessional behaviors.

Despite this, many sufferers have reported relief of OCD symptoms through use of this substance. Some scientists and doctors, commonly sympathetic to legalization of this substance, continue to research THC (delta 9-tetrahydrocannabinol), the active chemical in cannabis, in search of proof of beneficial effects.

The antidepressant, or "high" effects of THC is reported to be related to brain agents called "endo-cannabinoids". These are released during times of stress and anxiety. The receptors of endo-cannabinoids are called "CB1 cannabinoid receptors", and are linked to serotonin production. These CB1 receptors densely populate some areas the brain, including the basal ganglia, frontal lobe, and cerebellum. The cannabinoid system works primarily with memory.

When THC enters the system, it acts like endo-cannabinoids, stimulating the CB1 receptors in the memory sectors. This is believed to cause inhibition of memory function.

This process slows down the memory response system. Memory works with defense response, and this may slow down defense-related processes, such as that of the amygdala (fear).

This memory-reaction inhibition may be the cause behind the “zoning” feature of the high. “Ignoring” is a feature of memory. The brain tends to ignore “little” things, due to frequent exposure and insignificance of affect. The brain has learned that particular things are normal or “safe”, thus gives no particular attention to their appearance.

When this feature is inhibited, a person tends to notice things normally considered insignificant. Environmental elements are given a feel of newness, much like a baby's curiosity. This explains abnormal fascination with environmental stimulation, such as music, color, and movement. Thoughts tend to be more focused on details and examination increases.

This memory inhibition affects short-term memory function. This is apparent in the common circumstance in which the person starts a thought or sentence with one intention, but ends it somewhere else. Often, this is described as “lost track of thought”, or forgetting what one originally intended to say.

These effects are often amusing to the person, and are laughed at. However, some people find this lack of control to be disturbing. One person finds it amusing, and likes the affect of the “mind wondering”. Another, however, may find this threatening, as he or she can't trust personal function and judgment.

This is often described as paranoia. It is unknown why some are affected one way, and others another. This may have to do with dosage.

So far, research results indicate that, in low doses, THC can increase neuron activity, activating serotonin production. However, these same studies report that high doses of

THC actually drops the level of serotonin production, which can result in anxiety and depression.

Tolerance may be a consideration. Two people may not have the same tolerance to the same dose. Additionally, chemical balance or receptor function could make a difference in how one reacts to THC. Perhaps the increased serotonin production and release associated with THC is not absorbed due to dysfunction of synapse (absorption). This may cause one to miss the "feel good" effects of the chemical.

This may explain why some OCD sufferers report positive results from THC, while others say that it makes obsessions worse. Some feel that the "slowing down" effect helps anxiety (serotonin), and others say that it increases fears and obsessions (no serotonin).

This varying response is also found in the use of prescription medication. Different people respond differently to chemicals introduced to the brain.

Though many supporters of marijuana strongly object, studies show that THC effects can last well beyond the appearance of the "high".

Studies of airline pilot performance in flight simulation revealed results suggesting pilots were impaired as long as 24 hours after smoking marijuana. Routine operations, which had been "over-learned", and thus instinctual, performed fine. However, the pilots' responses to unexpected events were significantly slower and disorganized.

There has been no proof of long-term negative affects from the use of marijuana. There is debate about possible addictive features, as marijuana is often used to alleviate stress, a common trait among drug addicts.

Perhaps in consideration to the legal issues involved with the use of marijuana, some professionals have ventured into other ways to incorporate THC effects into the medical community. This resulted in the creation of synthetic THC, also called Dronabino, which is legally available by prescription in the United States. It has minor differences from natural THC, but effectively works the same.

Marijuana is illegal in the United States. Distribution, solicitation, possession, and use are prosecuted as illegal offenses. If one chooses to engage in marijuana use, he or she does so at the risk of fines and imprisonment.

Diet

Some foods contain serotonin, and there are many claims that eating such foods helps to increase serotonin in the brain. This is not proven, and it is argued that serotonin cannot be absorbed through ingestion. However, tryptophan is a precursor to the body's own production of serotonin, and can be absorbed through digestion. Tryptophan is common in foods such as dairy, nuts, and fowl, including chicken and turkey.

Tyrosine is also found in some foods, and can be helpful in the production of dopamine and norepinephrine. Foods containing tyrosine include cheese, beer, wine, liver, avocados, bananas, tomatoes, and spinach. Foods that are aged or fermented may also contain tyrosine.

People taking MAOIs or St. John's Wort should consult a physician before consuming foods containing tyrosine, as this may result in serotonin poisoning.

Avoiding stimulants, such as caffeine, can help reduce anxiety. A sufferer would benefit most from a diet that in-

cludes calming agents to reduce mental stimulation and stress.

Hypnosis and NLP

Hypnosis is a practice of unconscious suggestion made by a hypnotist. It is believed that when one is in a conscious yet "tranced" stated, he or she is more prone to psychological manipulation. A trained hypnotist is said be able to encourage a state of conscious sleep, in which the brain is "awake" but not in control. Responses and inhibitions to the environment are commanded by the hypnotist, rather than the brain's natural reactions.

In OCD, a hypnotist would likely work to untrain a person of the fears that result in anxiety. Though unrelated to CBT, the results are said to be similar. The difference is simply the conscious untraining in CBT, versus the *unconscious* untraining in hypnosis. Results may vary, and are not commonly permanent.

NLP, or Neurolinguistic Programming, is a process of retraining the mind based on grammar and word use. A practitioner would have the sufferer describe thoughts and beliefs in his or her own terms. Using the language used by the sufferer, the practitioner identifies generalizations, stereotyping, and other broad terms and uses those to inspire reflection in the sufferer. This is said to result in reviewing the choice of words. The choice of words and grammar changes to relate to specific meanings. This is said to help the sufferer realize mistakes and falsehoods in beliefs and thought patterns, effecting a change in defensive rationalizations.

This practice, and that of hypnosis is commonly consid-

ered to be alternative or "New Age" medicine. They are often discredited by those of medical profession.

And many more

Other therapies, such as acupuncture and massage, may be considered for their features of relaxation. These have had mixed reports regarding real impact on controlling OCD. The reduction of stress that may be achieved in these practices may impact the potential for anxiety episodes, but may only help in the short-term, or not at all in severe cases of OCD.

Meditation or meditative exercises, such as yoga, may be worth considering, as well. These inspire and require focus and calm. Both take time to learn. Additionally, the benefits are said to increase with practice.

Audio recordings specifically designed to aid calm and meditation are also available. Many have found that by listening to self-hypnosis recordings, recorded meditation guides, and instrumental compositions for calming have been helpful for reducing stress. Some may benefit from including alternative therapies in combination with CBT or counseling.

Incorporating one's chosen alternative therapy as part of regular routine is suggested for optimal benefits. Many of the therapies covered will only work while in effect (supplements), or for the short-term.

Chapter Ten:

Overview and Surviving Therapy

A lot of information has been covered in this book. This chapter will review the information in short form.

Therapy can sometimes be equally or more challenging than dealing with ROCD untreated.

This chapter will highlight some things one may expect during and after treatment.

When in an ROCD relationship, more patience and strength are needed than normal. It is understandable to feel lost sometimes. Not knowing what to do, what to say, or how to feel are frustrating circumstances. One's emotional strength is tested repeatedly, sometimes almost to the point of giving up and walking away.

Many ask themselves why they stay. The answer is usually love. Many get frustrated, knowing that they don't deserve to live with the effects of ROCD. Many may dabble with the idea of leaving the relationship. Most don't because they know the *real* person behind this is wonderful, and the idea of hurting their partner (and themselves) is unthinkable.

In chapter 1, you learned the identity of the monster that is ROCD. You gained insight to how it gets inside your partner's head and twists a good relationship beyond recognition. You also learned why your partner does some of the things he or she does. You may have gained some comfort in knowing that you are not alone.

Knowing what you are up against is important for knowing how to deal with it. The doubts, confusion, and frustration that you may have felt in the course of this relationship may now be replaced by understanding, and an ability to see past offenses. It may still be hard, but knowing what ROCD is should be helpful in getting through rough times without feeling lost or confused.

In chapter 2, you learned that OCD is behind ROCD, and that you are not dealing with something that hasn't been seen before. You gained insight into OCD, its many manifestations, and, perhaps, how it appears in your relationship. This should help by giving you comfort in knowing

that it isn't just the relationship, but much bigger than that.

To know ROCD is to know OCD. Although ROCD is specific to your relationship, OCD is the mastermind behind the obsessions, and lurks in the life of your partner. ROCD is simply a manifestation of OCD.

In chapter 3, you learned what may cause OCD. If it is environmental, you may have found something in common with what was covered. If it is a physiological problem, you know how it may manifest in the brain. Understanding these is helpful for knowing that it is not your fault. ROCD is there, whether you are or not. Additionally, it may provide relief for those who have experienced pain and frustration over not knowing why your partner behaves this way.

In chapter 4, you learned about ways you can protect yourself from becoming a victim. You learned about potential risks of developing your own emotional problems due to exposure to ROCD. You were provided with ways to change or control your own behaviors so you can prevent worsening things.

Part of that is realizing that you don't need to change anything about yourself, or argue about whatever hurtful declarations you may hear.

In chapter 5, you learned what to expect if a breakup or separation is considered or carried out. You learned that instead of fighting or arguing, it's best to stay calm. Recognize circumstances that are either within or beyond your control. By acknowledging these, you see where energy is wasted, and can focus on your real options.

In chapter 6, you learned one of the most important things a partner can learn: How to help. The only way a sufferer can get ROCD under control is if he or she recog-

nizes it, and *chooses* to get help. As a partner, you can't force this, but you can encourage it.

In chapters 4, 5, 6, the message was clear that whatever you do, either during a spike, or other times, should be done with love. You should not fight back if you intend to save the relationship. The best that you can do for your partner is be loving, understanding, and supportive, without enabling ROCD by accepting it.

In chapter 7, you learned ways to make sure you get the right help. You learned the differences between professionals that treat OCD. You learned strategic steps, and possible pitfalls in finding help. Additionally, there is no excuse to let financial problems or lack of insurance get in the way of getting treatment. You learned some alternatives to expensive conventional therapists.

In chapter 8, you were shown what can be expected in therapy. What medications are typically used, how they work, and why they are prescribed are all good things to know. This gives you power to be on top of the medical treatment your partner is receiving. Without it, you would be at the whim of the therapist, which isn't necessarily wise.

You learned how behavioral treatment is practiced, and why it works. You learned what your partner may go through if he or she begins that kind of therapy.

In chapter 9, you were provided with a summary of alternative "medicines" that may be used in place of prescribed medication. You now know the basics of how these work, how they are distributed, and what to expect. Some may be inclined to try supplemental alternatives over medications.

Overall, you received a "crash course" in ROCD and OCD. Now you know what you can expect if you continue

a relationship with an ROCD sufferer. The last to cover are things you should know and can expect during and after treatment.

Trial by Error

The first therapist you hire may not be the last. For example, everything may seem fine in the first few sessions, but later your partner expresses concern. These concerns may rise from problems with medication, treatment procedure, compatibility issues, or other things that can make one wonder if things are "right".

Success of therapy is largely dependent on the patient's confidence. If questions begin to surface about the quality of treatment your partner is receiving, it may be an indication that therapy is failing. This is especially the case if the sufferer feels like he or she is not being listened to. If he or she is open to receiving treatment, but the procedure or the professional doesn't feel right, it may be appropriate to find another therapist. Don't waste time and money on help that isn't working.

Try not to confuse this with discomfort with therapy. It is common for sufferers to feel uncomfortable when receiving help. The therapist may be just fine, but the sufferer is resisting, whether purposefully or not. One should decide whether this is the case before passing judgment on the therapist.

It gets worse before it gets better

If your partner begins Cognitive Behavioral Therapy that includes ERP (Exposure and Response Prevention), he or she will intentionally expose themselves to things that

cause spikes. Additionally, he or she won't be allowed to substantiate. The effects of this will not be confined to the session. Your partner will likely face weeks of difficulty and anxiety, both in and out of the therapist's office.

The anxiety may result from the forced resistance to behaviors. This will be very difficult for your partner to accomplish. He or she will probably fail at this many times before getting it right. This means the obsessional behavior of substantiating the relationship will occur quite often before it begins to subside.

As the subject of the obsessions, you will have to live with being examined and having your "flaws" regularly addressed on purpose. This may make things harder for you. Emotional reactions to this could affect your partner's progress. You should try to avoid making things harder by expressing your frustrations with this to him or her, and find another way to deal with it. It is all but bound to happen, so you should accept the likelihood that things will appear worse before they get better.

For help, talk to the therapist to find out what you can do to make this easier on yourself and how to cope with the effects of CBT.

Reverse Reactions

If medications are prescribed, you should pay particular attention to how they affect your partner. Studies show that roughly half of OCD sufferers respond positively to medication. This can mean one of two things for the other half. Either there was no effect at all or the effects were the opposite of or different from what was expected.

People respond to medication differently. If your partner

experiences *more* anxiety, or becomes depressed, tell the therapist immediately. There are a variety of medications available that are reported to help OCD. Don't settle for one that makes life harder for the sufferer.

Relapse

Symptoms of ROCD should eventually subside with treatment. However, it is possible for these return after therapy has stopped. Partners should prepare for therapy to be repeated, or even continuing long-term. Some sufferers may need regular help maintaining their control skills.

OCD is incurable, and can only be controlled. Sometimes, without regular practice and maintenance, symptoms reappear. It is also possible that OCD can develop in other ways, not associated with ROCD. OCD is a persistent disorder, and controlling it may require lifelong therapy. It is not appropriate to assume that because symptoms of ROCD appear to gone, so, too, is the problem.

Sufferers and partners should keep an eye out for symptoms of ROCD to reappear after therapy has stopped. Also, watch for new symptoms of OCD, such as obsessions or behaviors that never previously appeared. The sooner these are identified and addressed, the easier it will be to treat them. Catching them before they become severe may significantly reduce the sufferer's difficulty in regaining control.

ROCD symptoms may not go away completely. In this circumstance, partners and sufferers will need to learn to live with the disorder. Often, the severity of symptoms is significantly reduced, but still exist. Partners should be aware of the possibility that they may just have to accept

that ROCD will linger in the relationship.

Expectations should be adjusted in anticipation of these possibilities.

Relationship Therapy

Under the weight of emotional stress, the strength of relationships can weaken before and during therapy. It may helpful to seek couples or marriage counseling in addition to therapy for ROCD. Partners cannot expect to stay strong all the time under this kind of pressure.

A couples counselor may help to enable healthy release of hidden or unintentional resentments, and provide advice on how to get the relationship in good shape. The counselor can be a mediator between partners. He or she can provide insight to what is the core of problems, and how these can be resolved.

Best wishes to you both. May your relationship heal and grow strong. May you find the love you have and will struggle to reveal.

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Afterword:

Moving on from Loving a Sufferer

Advice for ex-partners suffering after a permanent separation initiated by their beloved ROCD sufferer.

It's nearly impossible to gain clarity and peace with something that makes so little sense and comes from out of nowhere. What I'm going to say is not going to provide you with a holy grail answer, and will be tough to hear. ROCD doesn't go away without serious therapy and an unwavering will on the part of the sufferer.

Nothing you can do will ever fix them, make it stop, and end your suffering as the ex-partner. Nothing you can imagine will ever help any of it make sense, so that you can have peace with understanding. Nothing about ROCD, as with OCD, is logical or rational. With that in mind, your primary focus should be on yourself, because that's the only thing you have any control over.

Being with someone with ROCD can destroy you, emotionally. The thing that sticks is always wondering and picking at what is wrong with you and why you are not good enough. It can get so severe that the perfectionist and judgmental view of yourself, which is never going to allow you to feel good about yourself, will diminish your self worth to the point that you will isolate and never trust yourself to find love and joy with someone else who doesn't have ROCD. It's like the judgments and nit-picking from the ROCD sufferer have been imprinted on you, and you're doing it to yourself. THAT is what you have to deal with, and quickly. You can't do anything about the sufferer, you can't change them or control them, and the more you try, the worse it'll get.

I have nothing to say that can truly heal your heart or give you hope that your relationship is salvageable. Chances are, if your partner returns to you, this is a cycle

that will keep going until either they get help or you are completely destroyed by the viciousness of their mental illness.

No, they're not bad people. No, they're not hurting you on purpose. But they're hurting you all the same.

We get one life on this planet, as far as we know. You need to make the choice of whether you will continue to allow this to stop precious happiness and fulfillment. If you do not want this for the rest of your life, you need to make that choice and walk away. I know that's not what you want to hear. But that's all I can suggest, if you're going to be all alone in recognizing the ROCD and being the only one willing to work on it — if they're not, you shouldn't. It's costing you too much, and you DO deserve better, even if you may not believe it at the moment. Do the self-work required to deprogram yourself from the criticisms you now lay on yourself because of what your partner did.

You can love a person and still walk away.

You don't have to think they're bad, or evil, or a jerk. You can remember the good times and think fondly of them, while separating yourself from the harm they unintentionally cause you, so YOU can live in peace, find someone who doesn't do those things to you, and move on with your life. No matter what you may tell yourself, your ROCD partner is not going to change unless they want to, see the problem in themselves (nearly impossible, because they only see the "problems" with you), and commit to YEARS of therapy. Chances of that happening for you are next to zero. Not to be a Debbie-Downer, those are just the facts.

Focus on healing yourself and taking control of what you can control, and leave what you can't. Work to rebuild your self esteem, DO NOT allow the bad self-talk that comes from the ROCD to live in your mind. You DO deserve to be happy, and while you love that person, it's okay — in fact necessary, to love yourself first and pursue your own happiness.

You don't owe them

We often stay with people who hurt us because we feel we owe them that. Yet, at the same time, they don't feel the same "owing" to stay with us. Your ROCD partner leaves you because he/she doesn't think you're the right one for them. Sure, the reasons are ridiculous and false, but they're leaving us, all the same, because we're not 'the one'.

Think about that. You are willing to stick it out with the nonsense ROCD does to the relationship, but they're not willing to stick it out with you. They're allowed to leave you to pursue their "one", but you're not allowing yourself to do the same. You are allowed to find your "one" who doesn't do this to you.

Why do you owe this person more than they're willing to give you? Are their motives for picking you apart and leaving you not selfish or self motivated? At what point are they considering your feelings in any of it? They're not.

Why are they allowed to think only for their own happiness and you're not allowed to think of your own? Stop the dance with the argument that 'deep inside they really love me'. While it's probably true, that's nothing to hang your hat on, if you're going to get put through all those hoops and whiplash; and the emotional damage that comes with it, with no end in sight.

They don't need you

Your partner will be fine without you. They'll move on and do it to someone else unless and until they realize, accept, and do something about the fact that it's not the people they are with that are the problem. They may even know that during normal times, but during spikes, they don't, and the cost to you is devastating. If they're not actively dealing with it, there's no hope for you. You don't owe them to stick around and suffer with them or for them, if they're not doing anything about it.

They're not sticking around with you, they're leaving you in the dust. Please, take care of yourself first. You owe it to yourself, you don't owe anything to anyone else. You can and will find peace and love, but sometimes it requires cutting the cord.

Put yourself first

Keep good people around you who can boost your mood, keep yourself busy so you don't think about the ROCD person, and work your way to acceptance and moving on. That advice stands whether they come back or not. No matter what, you need to work on your own happiness and not put yourself on pause, staying in limbo for something like ROCD. Don't waste precious time in life that you can't get back waiting for a miracle.

If you're not finding happiness where you are, lasting happiness — not intermittent, you have a right, and owe it to yourself to find it elsewhere, just like the sufferer seeks it elsewhere.

I know it's a harrowing experience. Please just remember, their inability to love consistently, to not constantly be looking for greener grass, to be able to hurt people who love

them the most — none of that is your fault. You don't own those things. That has everything to do with them and nothing to do with you. The fact that you're willing to take the crap that ROCD dishes and still be willing to stick around speaks VOLUMES of your capacity to love unconditionally. Give it to someone who will ALWAYS appreciate that and are willing to work on themselves to make sure that *they* deserve *you*!

Have faith.

All my best to you. It does get better once you remember that you deserve unconditional love, too. Best wishes and good luck.